State of Maryland / Department of Health and Mental Hygien 35001 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10 C **Physician** 2006 6:00a.M Sarah B. Nickson /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Catonsville Baltimore 730 Wilton Farm Drive 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 F Months Days Hours 216-28-4969 98 Yrs. Director Georgia 6/12/1908 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits itam 27 is marked other than "natural", or Itams 23a or 28e-f show other traumatic event. Its Madical Examinar must be notified at Baltimore MD Catonsville 1 ☐ Yes 2√ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 USA 730 Wilton Farm Drive death y Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after a and Mentat Hygiene. Is marked other than "natural", or Ital 1 ☐ Never Married 2 ☐ Married Specify: African-1 ☐ Yes 2 ZNo Specify: Saltimore, Maryland 21215-0036 À ₩idowed 4 Divorced American Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOTUSE national
CIVIL Service Employee 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3 rd SSA College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Will Brown Sr. Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21228 permit. Pages 1 and 2 st Department of Health and Important: If itam 27 Is n any Injury or other traun once. 730 Wilton Farm Drive, Catonsville, MD Adrienne D. Cooper/Gr, Daug. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State King Mem. Park 11-3-06 Woodlawn, MD * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Wylie F/H P.A. of Balto. Go 21. Signatur Funeral Service Licensee 9200 Liberty Rd., Randallstown, MD 21133 23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Demontra Physician /Medical ostructive Pulmonary Disease **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months?
1 Yes 2 No Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 1 🗌 Yes 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 EN/Outpatient 3 DOA Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 5 Pending investigation s after death. 1 Tes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospitel o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier cai 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 2006^{22.} Regisfrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygienes 35002 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Physician Eleanora Molloy Prince October 29, 2006 12:00 PM /Medical 4a Fecility Name (If not institution, give street and number)
Manor Care Chevy Chase 4b. City, Town, or Location of Death 4c. County of Death Examiner Chevy Chase Montgomery If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) 11/25/1913 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 WA 6. Sex **Funeral** Days 578-86-4833 Months Hours Min 1 □ M 2 🔀 F Director Usuel Residence of Deceden Pegas 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiena. Int: If Item 27 is marked other than "natural", or items 23s or 28s-1 show 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23s or 28s-f sho other traumatic event, the Medical Examiner must be notified at MD Montgomery 1 ☐ Yes 2 ☑ No Chevy Chase Funeral Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 7103 Pinehurst Pkwy. 20815-United States 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 M No Specify: Specify: White <u></u> 3 ☑ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Own Home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas M. Molloy Emilee Ainslie 2 19a Informant's Name/Relationship (Type, Print)
Thomas Marc Prince/Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7103 Pinehurst Pkwy. Chevy Chase, MD 20815-20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Nov 3 Dependment of important: if it any injury or conce. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Chesapeake Crematory Beltsville, Maryland 2006 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Rapp Funeral Eccremation Services MO0382 933 Gist Ave. Silver Spring, Maryland 20910-Johnson 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Ceuse (Final disease or condition resulting in death) Coronara Artery Examiner Physician/Medicai Examiner Attending Physician: The law raquiras that the death certificate be executed attending physician and for usa as the bunal-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieled events resulting in death) Last Due to (or as e consequence of) Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown sata has been signed to pega 2 should be det à 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2 📉 No 1 Yes 2 XNo certificata Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) s after death.
s after death.
si Director: After this c Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 1 Natural 5 ☐ Pending М 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ŏ fillad in To the Hospital within 24 hours a To the Funeral C 112 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 20850 0 #201 30. Neme end address of person who completed cause of death (Item 23a) (Type, Print) 9715 Medical CTE Dr. D.O. MD Dagar D. U.
32 Registrar's Signature Anyshiravcen 31. Date filed (Month, Day, Year)

DHMH 16 Rev 6/95

State

Registrar

NOV 0 9 2006

			1 - For State Registrar	State	of Maryla	nd / Depa	artmen rtificat			ind Me	-	giene Reg. No.	000	350	03
	Physici	% 20	1. Decedent's Name (First, Middle, t	Last)							2. Date of De Month	ath Day	/ Yea	3. Time	of Death
	/Medic Examir	al	Mary Katherine 4a. Facility Name (If not institution, g				4b. City,	Town, or	Location of		Novembe	r 2,	2006 County of De	7:08	3 A ^M
1		e T	Riverview Care (Esse		I I I I I I I I I I I I I I I I I I I	14 (12-0			Baltimo	re	
**	Funeral Director		216-09-6001	Sex 1□M 2 X F	7. Age (In yrs	: last birthday) Yrs.	If Under Months		If Under 2 Hours	Min.	8. Date of Bir (Month, Da 12/19/	th у, Year) 1916	9. 8 Ma	irthplace (State Country) ryland	or Foreign
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	cation							10d. Inside	City Limits
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. importent: if item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other treumatic svent, the Medical Exeminer must be notified at ance.	by Funeral Director	Maryland N/I	4	Ba	ltimore	10f. Zip	Code				10a Citi	izen of What (s 2 No
	3a or	io i	1829 Bank Street					231					ed Sta		
	ems 2	iner	11. Mantal Status	12. Was Dec	edent Ever in I	J.S. 13.	Was Dece	dent of Hi	ispanic Orig	in? (Spec	ify Yes or No			nerican Indian,	
36	rs after F, or It	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced		2 X No ve		1 ☐ Yes		Specify:		,		Specify:		
200	72 hou natura	ted	15. Decedent's (Specify only highest of	Education		16a. Dece	dent's Usua	al Occupa	ation during most	of working	0	16b. Ki	ind of Busines	hite ss/industry	
21215-0036	within ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT u	se retired)	Or WORKIN	g	_			
9 9	filed v Hygie other t	e Co	17. Father's Name (First, Middle, La	st)		Press	s Ope:	rato		r's Name	(First, Middle,		Sumame)		
lan	Aental Aental rked c	To Be	Walerian Chojnows	ski					Alexa	andra	Groma	cki			
Maryland	2 should he and he is ma		19a. Informant's Name/Relationship			19b. Mailir	ng Address	(Street a	and Number	r or Rural	Route Numbe	er, City o	r Town, State	, Zip Code)	
ē,	1 and Health 8m 27 ther to		Stanley Piaskows	ki - Son	20b.	6902 Place of Dispo			1	Da	undalk			21222 or Town, State	
JOL	Pages ent of ht: if its y or o		1 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Special Control Cont		State	cemetery, crer	matory or c	ther plac		11/04	/2006				n a
Baltimore,	permit. F Departme Importer any Injur		21. Signature of Funeral Service Lin		\ \ \	int Sta	Name an	d Addres	s of Facility	,				Maryla	
8	88 38		Tand &	Mil	en)								e, Mar	yland 2	
			23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final	mplications that if by one cause on it	caused the dea each line.	ath. Do not ent	er the mod	le of dyin	g, such as c	cardiac or	respiratory a	rrest,		Approxim Interval B Onset and	etween
	Physician /Medical		disease or condition resulting in death)	a	(or as a conse	mance of	~~10								
	Examiner		Conventielly list conditions	b	aexe	4	マナル	، ر	07	4,-	be.				
	be is	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conse	quence of):			U	1					
	te be executed ysicien and ie burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to	(or as a conse	quence of):	10 -								
3760,	ysicier ysicier ne buri	calE		d											
39	artifica ing ph e as th		IF FEMALE:	157											
Вох	eath ce attend for us	by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 2No	1□Live I	tcome of pregr birth 2 Fet nant at time of	af death 3	Ectopic pa						23d. Date of o Month	lelive <i>r</i> y Day	Year
P. O.	t the d	hysic	1 □ Yes 2 ØNo 9 □ Unknown	9□ Unkn		30	J Other (sp								
ds, F	Attending Physicien: The law requires that the death certifics in death. In death. In certificate hes been signed by the attending phe by the funeral director, page 2 should be detached for use as the funeral director.		Part II. Other significant conditions	contributing to d	leath but not re	sulting in the u	nderlying c	ause give	en in Part I.		23e. Did t			to the cause of Probably 4 [
OS	aw rec ss beer 2 shou	Completed									24a. Was		24b. Were	autopsy finding	s available
ž	The cate he	Com									autor perfo	rmed?	death'	ocompletion of ? as 2∐ No	Cause of
Vita Vita	sicien certific rector,	Be	25. Was case relerred to medical examiner?	Hospital:				Othe	200		(Check only o				
ō	g Phys er this eral di	n: To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date	of Injury	ER/Outpatier 28b. Time of		28c. Injury Work	4 X NUI		e 5 Resident			рөсify)	
ion	ending path. pr: Afte	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigat	ion	th, Day Year)	Injury	М		<br Yes 2 □ N	lo					
Division of Vital Records,	ei or Att s after de ni Direct	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	286. Place	e of Injury - At I ing, etc. <i>(Spe</i> c	nome, farm, str ufy)	eet, factory	y, office		2	8f. Location (: City or To	Street an wn, State	d Number or	Rural Route Nu	mber,
	To the Hospitei or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate hes been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edicai (29a. Certifier Certifying (Check only one)	Physician: To the aminer: On the band man	best of my kn basis of examin oner stated.	owledge, death ation and/or in	n occurred vestigation	at the tim , in my op	ne, date and pinion, death	d place, a	nd due to the d at the time,	cause(s) date and	and manner I place, and d	as stated. ue to the cause	(s)
	To th within To th comp	Me	29b. Signature and title of certifier					. License	number	:		29d. Dat	te signed (Mo	nth, Day, Year)	
	m							VO	55	1+1			11/03	106.	
	(')		30. Name and address of person who SEBASTIQH K	(1			Print) QSTE	RH	Aus	MICH	Bar	T.	Magal	106 . 10MB 2	1224
	Sta		31. Date filed (Month, Day, Year)	32.	egistrar's Sign	nature	aste	p	. 100	,,,,,,		-1.	1020	SIND X	100
5.	Registr	ar	NOV 0 3	LUUD	A Shand	Sed his	A SECOND OF THE PARTY OF								

State of Manufand / Department of Health and Mental Hydien® O.O.C. SCOOL

			1 - For State Registrar	State of Maryla	na / Dep <i>Ce</i>	artment of F rtificate of	ieaim and ivid Death	entai mygien Reg. N		35004
			Hegistrar Decedent's Name (First, Middle, La	ast)		ranoato or		2. Date of Death		3. Time of Death
	Physicia /Medic		HARRI I	- K2, USE	Ks				ay Year	MAZIZAM
	Examin		4a. Facility Name (If not institution, gr	ve street and number)		4b. City, Town, o	r Location of Death		c. County of Death	1
			144 NORTH HIC	KORD AVE		BITH.	R		HARFOR	
	Funeral Director		218-67-7123	Sex 7. Age (In yrs	s. last birthday, Yrs.	Months Days		8. Date of Birth (Month, Day, Yea F2 B - 2	9. Birth	place (State or Foreign intry)
	tand		Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or L	ocation				10d. Inside City Limits
	Mary I-f sh	tor	Marlan HARE	DRO.	ASI A	r.A				1 ☐ Yes 2 I No
	or 28s	irec	10e. Street and Number		400	10f. Zip Code		10g. C	itizen of What Cou	intry?
	death with the Maryland ime 23e or 28a-f show r must be notified at	raiD	144 NORTH HIS	KORY FIVE.		3101	4		V.S.A.	
36	be filed within 72 hours after death with the Marylan hat Hygiene. ad other than "naturel", or iteme 23e or 28e-f show event, the Madical Examente must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 35 Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	U.S. 13.	Was Decedent of H If Yes, specify Cubin 1 ☐ Yes 2 1 No	fispanic Origin? (Spea an, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	
21215-0036	2 hou		15. Decedent's E	Education	16a. Dece	edent's Usual Occup	pation	16b.	Kind of Business/I	ndustry
215	filed within 72 Hygiene. other then "nel	Completed	(Specify only highest gi	College (1-4or 5+)	life.	DO NOT use retire	oation during most of working d)	J/1	572/2R C	. 20DE
	filed wil Hygien other the	Con	10YRS		1702	Torriot.	アンハンドク	C2	DZ: 215	ŝ R ž
Maryland	be file	Be	17. Father's Name (First, Middle, Las				18. Mother's Name	(First, Middle, Maide	n Sumame)	
3	2 should be and Mental ie marked o	P_	HERRY 1 IARS	HALL DUCE		ing Address /Strant	and Number or Rural	KLZMC	or Tour State 7	in Codel A
Z Z	D 5 N 3		19a. Informant's Name/Relationship	Orc Va	0114	E STORY	and rediriber of Abrai	ant things, city	0.2 Ca	ip Code) 21014
ō,	Health tem 27 other tr		20a. Method of Disposition	206.	Place of Disp	osition (Name of			Location - City or 1	Town, State
Baltimore,	permit. Pages 1 an Depertment of Heal Important: if item 2 any injury or other once.		Donation 5 ☐ Other (Spec		Cemetery, cre	matory or other pla	(a) 11/0×-	d. R	Vicily	000/1906
≡	permit. F Depertme importar any injur		21. Significate of Funeral Service Lice		27 1200 01	2. Name and Addre	ss of Facility	03/4IB50	ATION SE	Wicis
Ö	E E E E		Noon Wash		200	SOO HAR	TERO REPO	PARKVILL	LURAPY 5	and ardour
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused the de	ath. Do not en	iter the mode of dyin	ng, such as cardiac or	respiratory arrest,		Approximate Interval Between
,	Physician		Immediate Cause (Final disease or condition	Lad	Street	10 1)0	ment	a.		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cons	equence of):					7
) L	Sequentially list conditions	b. Due to (or as a cons	equence of):					
	nsit	nine	Sacuration list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	20010 (0.00 20 20 00						
Ć.	execu	Examiner	that initiated events 'resulting in death) Last	C. Due to (or as a conse	equence of):					
68760	g physicien end as the burial-transli	edicai		d						
	ntifica ng ph		IF FEMALE:						Ì	
Vital Records, P.O. Box	The law requires that the death certificate be executed the been signed by the attending physicien and page 2 should be delached for use as the buriat-transit	by Physician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 € No 9 ☐ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of deli- Month	very Day Year
o.	that ti	, Ph	Part II. Other significant conditions	contributing to death but not re	esulting in the	underlying cause gr	ven in Part I.	23e. Did tobacco	use contribute to	the cause of death?
ds	uires sign lid be							1 ☐ Yes	2 % No 3 □ Pro	obably 4 Unknown
Ö	s beer	Completed						24a. Was an	24b. Were au	topsy findings available
æ	The lay te hes age 2	mo						autopsy performed?	death?	completion of cause of 2□ No
ā	ician: Th certificete ector, pag	BeC	25. Was case referred to medical				26. Place of Death		10 100	
>	Physic this ce al direc	ToE	examiner? 1 ☐ Yes 2∰No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatie	ent 3 DOA	ner: 4 ☐ Nursing Hon	ne 5 Residence	6 □Other (Spec	nfy)
Division of	ding Pl h. After ti funera	Certification:	27. Manner of Death □Manural 5 □ Pending 2 □ Accident investigati	28a. Date of Injury (Month, Day Year)	28b. Time Injury	Wo	ryat rk? Yes 2 □No	8d. Describe how in	jury occurred	
<u> S</u>	deat ctor: y the	fica	3 ☐ Suicide 6 ☐ Could not	be 28e. Place of Injury - At	home, farm, s			8f. Location (Street		ral Route Number,
á	et or setter	erti	4 Homicide determine	building, etc. (Spe	cify)			City or Town, Sta	ite)	
	To the Hospitel or Attending Physicien: The law within 24 hours effecteath. To the Funeral Director: Affect his certificate has completely filled in by the funeral director, page 2	Medical C		Physician: To the best of my kaminer: On the basis of examinand manner stated.						
	To the within To the comp	ž	29b. Signature and title of certifier			29c. Licens	se number	29d. E	ate signed (Month	, Day, Year)
7			1/8/	12 700 FA	cf	#3	2022	OE	1602 3	1.2006
	(1)		30. Name and address of person who	completed cause of death (II	em 23a) (Type	, Print)	7	1		Maci
	Y		21 Date flood (Month Con Vocal	04Ris 1	30,38.	SIZZUE	33105750	DAY ES	DOGWISTO	1 HAN 1860
	Sta Registi		31. Date filed (Month, Day, Year) NOV 0 3 2	32. Registrar's Sig	A A	and!				

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

35005 2006

		Registrar		Certificate (of Death		R	eg No. ZUL	0 0000
Physicia Medical Exami		Decedent's Name (First, Middle, L		e (1ers	2. Date of Dea Month October 1	Day Year 7, 2006	3 Time of Death 1950 hrs
		4a. Facility Name (if not institution, g Johns Hopkins Bayview			4b. City, Town Baltimor	or Location of	Death	4c. County of De	eath
Funeral Director		219-04-9335	Sex 7. Age (In	yrs. last birthday) 26 y	If Under 1 Months	Year If Under: Days Hours	24Hrs 8 Date of Bi		Birthplace (State or Foreign Country IARYI_AND
w any		Usual Residence of Decedent 10a. State 10b. County		. City, Town or Loc		-			10d. Inside City Limits
ith the Maryland 23a or 28a-f show notified at once.	Director	MD BAlti 10e. Street and Number		Pikes	10f. Zip Coo		1	0g. Citizen of What C	1 Yes 2 X No
with the ns 23a or		1610 Wood1	12. Was Decedent Ever		Vas Decedent o		n? (Specify Yes or No		nerican Indian, Black,
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene and Health and Active of Health III. If item 27 is marked other than "natural", or items 23a or 28a-f short other traumatic event, the Medical Examiner must be notified at once.	by Funeral	1 Never Married 2 Marri 3 Widowed 4 Divorc 15 Decedent's Education (Specify	1 Yes 2 X	No 1	Yes 2 X		Puerto Rican, etc.)	White, etc. A f 1 Specify. A I	rican- merican
5-0036 led within 72 hours all tygiene other than "natural" the Medical Examin	Completed	Elementary/Secondary (0-12) 12th	College (1-4 or 5+)	during		life. DO NOT us			mployed
21215-0036 uld be filed within 72 Mental Hygiene marked other than	Be	17. Eather's Name (First, Middle, La ROSS N • Ford				Dia	Name (First, Middle, nna R. F	ord	
MD 21 nd 2 should alth and Me m 27 is man	2	19a. Informant's Name/Relationship Dianna R. Ford	/Mother	163	10 Woo	dling V	Way, Pik		MD 21208
Baltimore, MD 21215-003 germit Pages I and 2 should be filed with Department of Health and Mental Hygiene Important: Ifficen 27 is marked other ti migury or other traumatic event, the Med		20a Method of Disposition 1 X Burial 2 Cremation 4 Donation 5 Other Spec	Removal from State	20b. Place of Disp crematory or King Me	other place) em. Pa	rk :	Date 10-24-06		wn, MD
Balt permit Depart Import injury		21 Signature of Fundal Service In		9:	200 LI	berty 1	Rd., Ran	dallstow	of Balto. C n, MD 21133
Physician /Medical Examiner		236 Fart I. Enter the disease of confailure. List only one duse on Immediate Cause (Final disease or condition resulting in death)	nplications that caused the deach line. a Blunt Force Trauma Due to (or as a conseque	a to the Head				est, shock, or heart	Approximate Interval Between Onset and Death
ed nsit	Examiner	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conseque c. Due to (or as a conseque						
760, cate be executed physician and he burial - transit	an/Medical		d AMENDED item#1	,perME,g86	1,11/3/06	TT			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkno	23c. If yes, outcome of 1 Live birth 4 Pregnant at time 9 Unknown	2	Fetal death Other (Specify)	3 Ectopic p	pregnancy	23d Date of delive Month	rery Day Year
P.O. Eres that the signed by the be detached	ā	Part II. Other significant condition	s contributing to death but	not resulting in the	e underlying cau	se given in Part			to the cause of death?
VINTELY OLCITE Sox 68: ing Plysician: The law requires that the death certificate has been signed by the attending turneral director, page 2 should be detached for use as it.	Completed		-				24a. Was autop perfo 1 • Yes	osy prior death	
is certif	Be	25. Was case referred to medical examiner?	Hospital: 1 / Inpatient	2 ER/Outpatie		Other	heck only one) Nursing Home 5	Residence 6 Ot	her
ion of long Ply eath After the funeral	tion: To	1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5 Pending		28b. Time of FOUND: 2300 hrs		Injury at Work? Yes 2 V	28d Describe Subject ass	how injury occurred	
Division of Hospital or Attendin 24 hours after death Funeral Director: A rethy filled in by the lur	Certification:	2 Accident Investig 3 Suicide 6 Could n 4 Homicide	ot be 28e. Place of Injury	- At home, farm, st	reet, factory, offi	ce building, etc.	or Town, S		Rural Route Number, City
To the Hospital within 24 hours. To the Funeral completely filled	Medical C	29a Certifier (Check only 1 Certifying Phys	ician: To the best of my knoter: On the basis of examina and manner stated	owledge, death occ			e, and due to the cau	se(s) and manner as s	tarted
# 3 F 8	Me	29b. Signature and title of certifier	and mariner stated			ense number		29d. Date signed (
5		30. Name and address of person whelissa Brassell, MD	o completed cause of death Assistant Medical Ex		Penn Stree	t, Baltimore,	MD 21201		
Si Regis	tate	31. Date filed (Month, Day, Year)	32. Registrar's S						

	7113		For State Registrar	State of Maryla		tment of H		ental Hygie	ZUUb	35006
	Physici /Medio	al .	1. Decedent's Name (First, Middle, L	Bullin		4b. City. Town, or	Location of Death	2. Date of Death Month CHber 3.	Day Year i 2006 4c. County of Death	3. Time of Death
#	Examir Funeral Director	er	SINAI HOSPITH	L OF BALTIM	MORE vrs. last birthday)	SALTIMO If Under 1 Year Months Days		8. Date of Birth (Month, Day, Ye	9 Birth	place (State or Foreign ntry)
Deu	h the Maryland r. 7. 28a-f ehow	tor	Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Loca	ation Ltimore	2	0 ~0 /		10d. Inside City Limits 1 XYes 2 ☐ No
FIN,	th with	Funeral Director	10e. Street and Number 4105 Newtor 11. Marital Status	7 Ave	n U.S. 13. W	10f. Zip Code 2/2	215		Citizen of What Cou	1
5-0036	172 hours after dea "naturel", or Items	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	11	Yes, specify Cubai ☐ Yes 2 No nt's Usual Occupa	spanic Origin? (Spe n, Mexican, Puerto I Specify:		Specify: Bloom. Kind of Business/in	ick
71 2 2121	be filed within 72 ho tal Hygiene. d other then *natu	Completed	(Specify only highest of Elementary/Secondary (0-12)	College (1-4or 5+)	(Give ki	nd of work done of NOT use retired	turing most of working) OPCrato	ng	nion me	ŕ
Armu Maryland	2 should and Men Is marka aumatic	To Be	Willie Jackson 19a. Informant's Name/Relationship	(Type, Print)			and Number or Rura	l Route Number, Ci	al ity or Town, State, Zij	o Code)
H Baltimore, P	f Heel		Wanda Huffin - Y 20a. Method of Disposition 1 XBurial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec	Removal from State	b. Place of Disposicementary, crematery, crematery	atory or other place	e) 11· 5 ·	2004 +	Sal MO C. Location - City or T Arbutus	own, State
Balt	permit. Pege Department of Important: If any Injury or ance.		21. Signature of Funeral Service Lic Yaun C. (2) 23a. Part1. Ever the disease, or co	emplications that caused the d	22.	Name and Addres		andall	sween fi	Approximate Interval Between
0	Physician /Medical Examiner		shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	a	Sequence of):	SMALL	- BOWEL	IN		Onset and Death
8760,	icate be executed physicien and sthe burial-transit	dicai Examiner	Sequentiatly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a constitution of the constit	sequence of):	HEQUI	П			
Division of Vital Records, P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Diractor: After this certificate has been signed by the ettending ph completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 22 No 9 □ Unknown	23c. If yes, outcome of pre 1☐ Live birth 2☐ F 4☐ Pregnant at time of 9☐ Unknown	etat death 3 E	Ectopic pregnancy Other (specify)			23d. Date of detive Month	ery Day Year
ords, P	equires that ien signed b ould be deta	ted by Pt	Part II. Other significant conditions MORBID OB	ESITY, COPO	_		en in Part I.		co use contribute to t	
tal Reco	in: The law r ificete hes be or, page 2 sh	e Completed by	HYPELTEN 25. Was case referred to medical	VSION			00 Ph	24a. Was an autopsy performed 12 Yes 2	i? death?	opsy findings available impletion of cause of
on of Vi	iding Physicle th. After this cert funeral direct	To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Accident investigat	28a. Date of Injury (Month, Day Year	2 ER/Outpatient 28b. Time of tnjury	3 DOA Othe	4 Nursing Hor		e 6 Other (Speci	(ty)
Divisi	pital or Attar ours after dea eral Diractor illed in by the	i Certification:	3 Suicide 6 Could not determine	be Ose Bless of taken A	ecify)	et, factory, office	2	City or Town, S		
	To the Hos within 24 ho To the Fun sompletely	Medicai	(Check only 2 ☐ Medical Exone) 29b. Signature and title of certifier	aminer: On the basis of exam and manner stated.	nination and/or inve	estigation, in my or	pinion, death occurre	ed at the time, date	and place, and due to Date signed (Month,	Day, Year)
	4		30. Name and address of person whe CHRISTIAN MINSHALL	o completed cause of death (ttern 23a) (Type, P	rint) AF BALL	TIMOLE	a	Jober 31	, 2006
	Sta Regista	-	31. Date filed (Month, Day, Year)	A.	ignature	and I				

	1 - For State Regist	***	State of Maryla	-	ertificate of De	eath	Reg. N	711116	35007
Physicia /Medica Examine	MAR	Name (First, Middle, L KATHERN Name (If not institution, gi	ue Ruzici	LA	4b. City, Town, or Lo		Date of Death Month	Day Year 2006 1c. County of Deal	3. Time of Death 3. 2.25 PM
Funeral Director	1013	MOUNTAIN	TOP RD.	s. last birthday Yrs.		OLIS f Under 24 Hrs. 8 Hours Min.	Date of Birth (Month, Day, Yea	ir) " [Qo	RUNDEL hplace (State or Foreign unity)
70	10a. State	dence of Decedent 10b. County ANNE A	RUNDEL 10c. (City, Town or L	ocation		_ _ _ _ _ _ _ _ _		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
death with the Maryland me 23a or 28e-f show rmast be notified at	7684	and Number	BEACH AT	٥٠	10f. Zip Code	22		Citizen of What Co	4.
15-0036 72 hours after dearnaturel, or itsme	3 ₩ io	Status ver Married 2 Married dowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	U.S. 13	. Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 ☑ No	anic Origin? (Speci Mexican, Puerto Ri Specify:	ty Yes or No- can, etc.)	14. Race - Ame Black, Whit	
withir than	Ö	15. Decedent's (Specify only highest g ary/Secondary (0-12)	College (1-4or 5+)	(Giv life.	edent's Usual Occupation e kind of work done dur DO NOT use retired)	ing most of working LER	(Kind of Business	HOME
Maryland 2 d 2 should be filed th and Mental Hygi t? Is marked other traumatic avent.	o Ri	s Name (First, Middle, Las LEY F, nant's Name/Relationship	BROWN	19b. M ai	ling Address (Street and		RGA	HOAMS	
ges 1 and 2	20a. Metho 1 □ Bu	RAL-DUDLE od of Disposition urial 2 Ocemation 3	Removal from State	Place of Disp cemetery, cri	Dosition (Name of ematory or other place)	TOP RD.	ANNAA.	Lis MD - Location - City or	21409 Town, State
Baltimore permit. Pages 1 Department of He important: if iten any injury or oth		onation 5 Other (Specure of Fune all Service Lic		ATOMY G	22. Name and Address of Daugherty Fan	ay il-l- of Facility nily Funeral Hom ountain Road -	e And Cremation	Center, P.A.	MD,
Physician /Medical		Cause (Final condition	nplications that pause 12 e or y one cluse on each the.	evel	nter the mode of dying,	such as cardiac or i	espiratory arrest,		Approximate Interval Between Onset and Death
Examiner	Sequential if any, lead cause. En	lly list conditions, ling to immediate ter Underlying sease or injury	b. Due to (or as a conse						
76(Ite be lysicie	resulting in	sease or injury ad events in death) Last	Due to (or as a conse	equence of):					
Box 6 death certific e ettending p d for use as	IF FEMALE 23b. Was on the 1 🗆 Y	E: decedent pregnant past 12 months? 'es 2 11 No	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of	etal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	ivery Day Year
	מ רמונוו. טווי	er significant conditions	contributing to death but not r	esulting in the	underlying cause given	in Part I.		/	o the cause of death?
Division of Vital Records, for Attanding Physicien: The law requires tafter death. Director: After this certificate has been signed in by the funeral director, page 2 should be	EOO 25. Was ca	ase referred to medical					24a. Was an autopsy performed 1 Yes 2	prior to death?	utopsy findings available completion of cause of
n of Vita ng Physicien: Iter this certific neral director,	examin O 1 Ye	ner? es 2 1 10 10 10 10 10 10 10 10 10 10 10 10 1	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpation	of 28c. Injury at	4 INUISING HOME			city) seufflers
Division of Vital Re To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	2 ☐ Ad 3 ☐ Su	cident investigati	be 390 Place of Injury At	home, farm, s	M 1 ☐ Ye	s 2□No	f. Location (Street City or Town, Sta		ural Route Number,
To the Hospitel within 24 hours a To the Funerel Completely filled	29a. Certif (Chec one)	k only 2 Medical Ex	nysician. To the best of my kaminer: On the basis of examinand manner stated.	nowledge, dea nation and/or	investigation, in my opin	ion, death occurred	at the time, date a	and place, and due	to the cause(s)
P. M.	•	and title of certifier	o completed cause of death (It	tem 23a) (Type		8508	29d. I	Date signed (Mont	206
Stat Registra	e 31. Date fi	led (Month, Day, Year) NOV 0 3 200	32. Registrar's Sig	Carry		p, 66, B	UNK, A	1200	4

State of Maryland / Department of Health and Mental Hygier [] [] [Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 31,2006 **Physician** MARGARET LEE SUGG /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2310 Foster Avenue Parkville Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day Year) 925 North Carolina 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Months 1 □ M 2 X F 81 212-38-0341 Yrs. Director Usual Residence of Decedent deeth with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryla Department of Health and Mentel Hygiene. Important: if item 27 is marked other then "natural", or iteme 23a or 28e-f shown my injury or other treumatic event, the Medical Examinant institute the notified at once. Director MD Baltimore Parkville 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2310 Foster Avenue 21234 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. ☐ Yes 2X No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☐XNo Specify: 3X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Maryland School For Kitchen Aide 12 the Blind 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leon McLawhorn Rosa McCoy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S. Edward Sugg- Son 8019 Yellowstone Road-Kingsville, MD 21087 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Parkwood Cemetery 1 Burial 2 □ Cremation 3 □ Removal from State 11-6-06 Parkville, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility EVANS FUNERAL CHAPFL AND CREMATION SERVICE 21. Signature of Funeral Service Licensee ondrae hy **SERVICES** troboli Parkville, Maryland 21234 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Myocarnia 10 MIN /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner physicien and s the burial-transit or Attending Physicien: The law requires thet the death certificate be executed resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical anding phy. IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ned by the etter detached for u in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day 4☐Pregnant at time of death 5 Other (specify) 9∏ Unknown page 2 should be de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ğ 3 Probably 4 Unknown 1 ☐ Yes 22 No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 22 No 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Medicai Certification: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending within 24 hours after death.

To the Funerel Director: A completely filled in by the fu М 1 □ Yes 2 □ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei ţ 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHAEL 11A2FO 22 MD y. Year) 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 35009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Yeer 0dess Cleveland Smith 11:00A M October 24, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gaithersburg Wilson Health Care Center Montgomery If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Nov. 22, 1908 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 103 M 2□ F 97 Alabama Director 418-07-2692 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No Gaithersburg Montgomery Direct 10e. Street and Number 10f. Zin Code 10g, Citizen of What Country? 9001 Green Run Way 20879 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 🔼 No If Yes, Give Year or Dates: 1 Never Married 2 Marned Specify: White 1 ☐ Yes 21 No þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Convenience Stores/ Elementary/Secondary (0-12) College (1-4or 5+) Rooming House permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: if Item 27 is marked other It any njury or other traumatic event, Its 2006 12 Management 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Surname) Andrew Jackson Smith Ella Arnold 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1592 Bowman Circle Pell City, Alabama 35125 Jerry C. Smith 20b. Place of Disposition (Name of cometery, crematory or other place, Jefferson Memorial 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 10-28-06 4 Denation 5 Other (Specify) Birmingham, AL Gardens East 21. Signature of Funeral Service Licenses Jefferson Memorial Funeral Home 22. Name and Address of Facility 1591 Gadsden Hwy, Birmingham, AL 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 1400 /Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 been sig 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe page 1□ Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death Check only one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I retifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as arranged.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar

31. Date filed (Month, Day, Year) 2006

M VEMURY MD.

30. Name and address of person who completed cause of death fitem 23a) (Type, Print)

9801

AVE, SILVER SPRING, GEORGIA 32. Registrar's Signature

D35791

10/25/06

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 350 I O Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deat Year **Physician** Lawrence Shepherd October 0 18, 2006 6:10 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 479 Eastern Court Harford Aberdeen If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 6. Sex **Funeral** Months Davs Hours 1 ☐ M 2 ☐ F 235-82-0040 56 Director May 5, 1950 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland | Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 479 Eastern Court 21001 U.S.A. Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Media once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Coal Miner Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jess Shepherd Edna Richards ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Beverly Campbell-Shepherd (Wife) 479 Eastern Ct., Aberdeen, MD 21001 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 10/24/06 1 N Burial 2 □ Cremation 3 □ Removal from State Laeger Memorial Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Roderfield, WV 21. Signature of Funeral Service Licenson 22 Name and Address of Facility
Fanning Funeral Home U.S. Highway 52 N., Laeger, WV 24844 linen Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ancel mill disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner use as the burial-trans Due to (or as a consequence of): P.O. Box 687605 physician IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy atter for u in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a detached i 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🚻 Unknown 24b. Were autopsy findings available prior to completion of cause of death? cate has autopsy performed? Yes 2 No 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 ☐ Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After th
completely filled in by the funeral

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

THA M

NOV 0

MYO

31. Date filed (Month, Day,

ROM

PHILADELPILIA

BALTU,

and manner stated.

32. Registrar's Signature

30. Name and addr of person who completed cause of death (Item 23a) (Type, Print)

	-	For State Registrar	State of M	aryland / Depa	artment <i>rtificate</i>				Reg.	71111	35011
Physici /Medi	al	1. Decedent's Name (First, Middle, Last) Charles N			4b Ciby T	Our of	Location of Deat			Day Yes 31, 200	6 12:30P ^M
Examir	er	4a. Facility Name (If not institution, give si 211 Hatchett Ro					ville			,	Anne's
Funeral Director		5. Social Security Number 6. Sex		ge (In yrs. last birthday) 73 Yrs.	If Under 1		If Under 24 Hrs Hours Min.	8. Date of (Mont)	of Birth n, Day, Ye 17,1		Birthplace (State or Foreign Country) ryland
pu k		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation						10d. Inside City Limits
Maryla f eho	ro	Maryland Queen An	ne's	Centre							1 Yes 2 No
or 28a	Director	10e. Street and Number			10f. Zip (Code			10g.	Citizen of What	Country?
ath will	raic	211 Hatchett Road				1617				USA	1-4
permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Depertment of Heatth and Mental Hygiene. Important: if item 27 is marked other then "neturel", or iteme 23a or 28a-f show eny injury or other traumatic event, the Madical Examinar must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	2. Was Decedent Armed Forces' 1 XYes 2 ☐ If Yes, Give Year or Dates:	? No	Was Decede If Yes, speci	ty Cubar	spanic Origin? (S n, Mexican, Puer Specify:	ipecity Yes o to Rican, etc	or No- :.)		merican Indian, /hite, etc. White
permit. Pages 1 end 2 should be filed within 72 hours all Depertment of Health and Mental Hygiene. If item 27 is marked other then "neturel", or any injury or other traumatic event, the Madical Examinate.	Completed b	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Dece (Give life.	edent's Usual kind of work DO NOT use	k done d	uring most of wo	rking	160	b. Kind of Busine	ss/Industry
yiene.	mo.	Elementary/Secondary (0-12)	College (1-4or		ystems	Mar	ager			Telep1	hone
al Hyg	BeC	17. Father's Name (First, Middle, Last)					18. Mother's Na	me (First, M	iddle, Mai	iden Sumame)	
ould to	2	Charles N. Schatz	B 114	405 14-14		/011				inweide	
d 2 sh th and th and T is rr traum		19a. Informant's Name/Relationship (Type) Joan Schatz	Wife							ity or Town, Stat	
s 1 en of Heal item 2		20a. Method of Disposition		20b. Place of Disp	osition (Nam	e of		Date		c. Location - City	
Page nent c ant: if ury or		1X Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Crest L	awn Me	m. C	ard. 11		_		ville, MD
Depentit. Depentit Import eny inj		21. Signature of Funeral Service License	toto	Fi	uneral 630 Ed	Hon	ne of Ca Ison Ave	tonsvi nue: (lle, Laton	Inc. sville.	wab Witzke _MD 21228
Pnysician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each	s a consequence of):	nter the mode	Co	such as cardia	Cov			Approximate Interval Between Onset and Death
cate be executed by sicien and the burial-transit on	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a	s a consequence of):							
The law requires that the death certificate be executed the has been signed by the attending physicien and bage 2 should be detached for use es the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetel death 3	□Ectopic pre			411 m		23d. Date of Month	delivery Day Year
uires that the signed by the	Þ	Part II. Other significant conditions con	tributing to death	but not resulting in the	underlying ca	ause give	en in Part I.	23e.			te to the cause of death? Probably 4 XIUnknow
sician: The taw requires to certificate has been signe irector, page 2 should be o	Completed							24a.	Was an autopsy performe	d? prior	e autopsy findings availabl r to completion of cause of h? Yes 2□ No
	Bec	25. Was case referred to medical examiner?					26. Place of De				
Physician: r this certific rral director,	2	1 ☐ Yes 2 🙀 No	lospital: 1 Inpa				4 Nursing			ce 6 □Other (Specify)
ding After fune	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of In (Month, D	Jay Year) Injury	М		y at k? Yes 2 □ No			injury occurred	
itel or Attenurs after deall		4 Homicide determined	building,	njury - At home, farm, s etc. <i>(Specify)</i>				City	or Town,	State)	or Rural Route Number,
To the Hospitel within 24 hours a To the Funerei Completely filled	Medical			st of my knowledge, dea of examination and/or- stated.							
To the vithin. To the comple	Me	29b. Signature and title of certifier			290	. Licens	number		29d	I. Date signed (A	Nonth, Day, Year)
		1/	HC.	-MD	_ 7	Do	0613	21		11/2/	06
2 1		30. Name and address of person when the					_			01617	
		Semra Sahinci, MI) Pennsylva strar's Signature	nia Av	enu	e; Centr	evill	e, MI	21617	Alleger
S: Regis	trar	31. Date filed (Month, Day, Year)		ouar s orgnature	ASSE -	20					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** JMITH 8:10 P M ohn October 2006 /Medical 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** SEWYEU CITY 139 Him OR E If Under 1 Year If Under 24 Hrs. HOSPi 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days Months Hours Min 225-38-8824 1 X M 2 □ F Carolina 32 North Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County and Mental Hygiene. Is marked other than "naturel" or Iteme 23s or 28e-f show reumatic event, the Madical Examinar mast be notified at Maryland 1 Yes 2 No **Completed by Funeral Director** more 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code #205 32 2 filed within 72 hours after deeth 12. Was Decedent Ever in U.S Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Slac 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) lanagei Dimons Shipbuilder × 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Peges 1 and 2 should be file Depertment of Health and Mental Hy Important: If Item 27 is marked oth any linjury or other traumatic event <u>QNR</u>. Be ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) salto srown 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State torest 4 ☐ Donation 5 ☐ Other (Specify) Garrison 21. Signature of Funeral Service Licensee 22. Name and Addr Joseph Funeral Hove. Balto. Home, P. A. North Approximate Interval Between Onset and Death Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart tallure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) HEART **Physician** AtWERDSCLERATIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine led by the ettending physicien and detached for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ 3 Probably 4 ⊟triknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? To the Hospital or Attending Physicien: The law within 24 hours after death.
To the Funeral Director: After this certificate has recmpletely filled in by the funeral director, page 2 v. autopsy performed' 2 1 No 2 1 No 1 Tyes 1 Yes of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 🗌 Yes 2 1410 1 Inpatient 2 VEH Outpatient 3 DOA 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Division 5 🗌 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Cartifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the dause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number who completed cause of death (Item 23a) (Type, Print) Street Ballingre MI Baltimore 2000 West 31. Date filed (Month, Day. 32. Registrar's Signature State

Registrar

			1 - For Amend #5 Per	State of Maryland FH G861 11/20	/ Depa 0 / 06 0 / 06	irtment of H	lealth and I Death	Mental Hygi	iene og. No.	35013
	Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, Last) 4a. Facility Name (If not institution, give s	SCHULT treet and number)	Z	4b. City, Town, or	r Location of Death	2. Date of Death Month	Day Year 200	
	Funeral Director		Mariner Health of 5216 S03 in 1109	of Glen Burn M 28 F 7. Age (In yrs. Ia:		Glen If Under 1 Year Months Days	Burnie If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 05/12/	Year) C	runde1 httplace (State or Foreign ountry) MD
	e-f show	ctor	10a. State 10b. County MD Anne Art		Town or Lo					10d. Inside City Limits 1 ☐ Yes 2€No
	ith with the 23a or 28 ust be no	Funeral Director	10e. Street and Number 8489 Arbutus Dr	ive		10f. Zip Code 21122		10	Og. Citizen of What Co	ountry?
980	hours after death with the Maryland turel', or Items 23a or 28e-f show al Exporting must be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 Mo If Yes, Give Year or Dates:	1	Vas Decedent of H f Yes, specify Cuba I ☐ Yes 2 ☑ No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whi	
Maryland 21215-0036	within 72 ane. than "nai	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give life. l	tent's Usual Occup kind of work done DO NOT use retired maker	ation during most of wor d)	king	16b. Kind of Business	·
land 2	be filed htal Hyg hd othe svsnt,	To Be Co	17. Father's Name (First, Middle, Last) Samuel Herman		1101110	Maries		ne (First, Middle, M	Maiden Sumame)	!
	d S d S		19a. Informant's Name/Relationship (Type Patricia Becker	/Daughter	8489	Arbutu	s Drive		City or Town, State,	
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		20a. Method of Disposition Enton 1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	Grd	ns of	sition (Name of natory or other place Fth Ce . Name and Addre	m 11/0	02/06 H	Baltimore Funeral	e, MD
8	Pe B E E	10	23a. Part1. Enter the disease, or complications, or heart failure. List only on	cations that caused the death.					sadena, M	AD 21122 Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	ChRONIC Due to (or as a conseque	OBS ence of):	TRUCT	IVE PU	LMONTR.	Y DLIGASE	Onset and Death
8760 _x	ate be executed hysician and he burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque						
O. Box 68	The law requires that the death certificate be executed tie has been signed by the attending physician and tage 2 should be deteched for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregnan 1 □Live birth 2 □ Fetal (4 □ Pregnant at time of dea 9 □ Unknown	death 3□	Ectopic pregnancy	<u>'</u>		23d. Date of de Month	olivery Day Year
rds, P	quires that in signed b uld be dete	by	Part II. Other significant conditions con	tributing to death but not resul	lting in the u	nderlying cause giv	en in Part I.			o the cause of death?
Vital Records,		Completed							prior to death?	utopsy findings available completion of cause of s 2 No
of	ling Phys After this uneral dii	ation: To Be	27. Manner of Death Natural 5 Pending 2 Accident investigation		PVOutpatier 28b. Time of Injury	28c. Injur Wor	er: 4 Nursing H		e) Ince 6 Other (Sperw injury occurred	acity)
Division	- 0 -	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)		eet, factory, office		28f. Location (Sti City or Town	reet and Number or R , State)	lural Route Number,
	To the Hospitel of within 24 hours aft To the Funerel D completely filled it	edical		sician: To the best of my know ner: On the basis of examination and manner stated.				irred at the time, da	ate and place, and du	e to the cause(s)
)	To the To the complet	W	29b. Signature and title of certifier 30. Name and address of person who co	mpleted cause of death (Item	4LME 23a) (Type,	MONT DE	on number	VE MUL	9d. Date signed (Mon CTO BER ALON	th, Day, Year) -,31,2006
	Sta Regist		31. Date filed (Month, Day, Year) NOV 0.3 2006	32. Registrar's Signatu	ure	ENVE	BAL	TIMO	RE M	D 21226

Registrar
DHMH 17 Rev 1/2001

State

STEVEN R AXE,

31. Date filed (Month, Day, Year)

M.D.

3 2006

32. Registrar's Signature

ORIGINAL

7601 OSLER DRIVE

TOWSON, MARYLAND 21204

Steven Shamaur Sharrod Silver

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2	0	0	-	2	-	0	1
4	U	U	O	J	J	U	1

		Registrar						ate of		h				Reg. No		UU	,)	001
Physicia edical Exami		1. Decedent's Nam	e (First, Midd teven	ie,Last)	Steven nama u	Shamaur r Sheri	Shar cod (rod Si	lver			2	Date of D Month October	eath Day	Yea	r _i	3. Time 1350	of Death) hrs
		4a Facility Name (on, give st	reet and n	umber)		4	b. City, 1 Baltin	Town, or L	ocation of	Death			c. County o	of Death		
Funeral Director		5. Social Security I		6. Sex		7. Age (In yr	s. last birt	thday)	If Und	er 1 Year	If Under Hours	24Hrs.		,	M/DD/YYYY	9. Birt		tate or
Director		220-17-0 Usual Residence of		1 X M	2 F	29		Yrs.	I WIGHT	Days	Hours	10	04-0	09-1	977	Co	untry)	Md.
y a a		10a. State	10b. County			10c. C	ity, Town	or Locatio	on		-						10d. Insi	de City Limits
land f show	ō	Md.	NA				I	Balti	more	9							1 X Y	es 2 No
Baltimore, MD 21215-0036 penil. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event. The Medical Examiner must be notified at once.	Director	10e. Street and Nu		venu	е				10f. Zip	Code 21213				10g C	itizen of Wh USA	at Cour	ntry?	
th with : ems 23s	uneral	11 Marital Status 1 X Never Marri				cedent Ever in	U.S.						cify Yes or I	No-	14. Race White		can India	n, Błack,
uter dea I'', or it	II.	3 Widowed		orced If	Yes Yes, Giva Ye	2 X No)			X No					Specify:		ick	
hours a natura	ed by	15 Decedent's E		cify only i				Decedent during mo						16b.	Kind of Bu			ork
5-0036 lled within 72 Hygiene I other than "	Complete	Elementary/Secondary 12th gr			College (1-4 or 5+)		Ware			JO 110 1 0		۵,	J	ones	Indu		
filed wi Hygie d other		17. Father's Name Maur		, Last)	D-1	7		,		18		,		, Maide	n Surname)			
2121 ould be fi Mental marked	To Be	19a. Informant's Na		ship (Type	Ra			lver	Address	(Street a		er or Ru		umber.	Richa City or Towr			9)
MD and 2 sho alth and m 27 is		Sharron	_	on	N	Mother		418	Woo	dcres	st Dr	ive,	Aber	deer	n, Md.	2.	1001	
Baltimore, permit. Pages I are Department of Hea Important: If iten injury or other tr		20a. Method of Dis 1 XBurial 2	Crematio		Removal fi		cremat	of Disposit ory or other of Mer	er place)	1			Date .9-06	- 1	Location - Randal	-		
taltin rmit. Pr spartmen nportan jury or		4 Donation 5 21. Signature of Fu	Other S ineral Service							Address o					I. Eas		JWII,	rid.
and the second		Gladys War	rren (pe	r DVR)	<u> </u>		110	Ol E	. Nor	th A	venu	e, Ba	ltin	ore,	Md.	212	202
Physician /Medical		23a. Part I. Enter the failure. List on	ne disease, or ily one cause	on each	line.			ot enter the	e mode d	of dying, su	uch as car	diac or r	espiratory a	rrest, st	nock, or hea	rt	Betwee	mate Interval en Onset and
Examiner		Immediate Cause (or condition resulti				itis com		ting p	neum	onia_								Death
	ē	Sequentially list co		b. Due	to (or as a	consequence	e off:	,										
	Examine	cause. Enter Unde (Disease or injury t events resulting in	erlying Cause hat initiated	C.		consequence						-						
secuted and transit		events resulting in	death) Last	d.														
60, te be exe ysician burial -	n/Medical	UNPENDED		X A	MENDED	期 ;21,2	3a,27	,perME	/21/0 , H,	6	, 12/1	1/06	TT					
68760, ertificate be ding physic e as the bur	an/N	IF FEMALE 23b. Was decedent past 12 months		ne .	Live t	outcome of prointh	2	Feta	al death	3	Ectopic p	pregnanc	су	23	3d. Date of o Month		ay	Year
Box 6 e death cert the attending ed for use a	Physicia	1 Yes 2 1	No 9 Un	known	death Unkn		5	Othe	er (Spec	cify)			15.1					
P.O. s that th ned by	by P	Part II. Other signi	ficant condi	ions co	ntributing to	o death but no	t resulting	g in the un	derlying	cause giv	en in Part	I.			No 3	_		-
ords, P w requires to is been signs should be d	eted					-						_	24a. Wa	s an	24b W	ere aut	opsy find	ings available
of Vital Records, ag Physician: The law require. The this certificate has been si neral director, page 2 should be	Completed									-		_		opsy formed?	de	rior to co eath? ✔ Ye:		of cause of
tal Recian: The	BeC	25. Was case refer examiner?	red to medica						2	26.Place o		heck on	ly one)			<u>.</u>		L
Physical this eral dir	ဥ	[4]	2 No	Hosp	28a. Date	Inpatient 2		utpatient Time of Inj		•••			Home 5		ence 6 🗸		Scene	
ion c tending eath. or: Aft the fune	ıtion:	1 X Natural	5 Pen		(Month	a, Day,Year)	200.	rime or mj	ury 2	28c. Injury 1 Ye	s 2 N		od. Describ	e now in	ju ry occu rre	d		
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Certification:	2 Accident 3 Suicide 4 Homicide	6 Cou	stigation d not be rmined	28e. Plac (Specify)	ce of Injury - Af	t home, fa	arm, street	, factory,	, office bui	lding, etc.	2	8f. Location or Town,		and Numbe	r or Rur	al Route	Number, City
To the Hos within 24 hd To the Fun completely i	Medical C	29a. Certifier (Check only one) 2	Certifying P Medical Exa	miner: Or	To the bes	st of my knowl of examination	edge, dea n and/or ir	ath occurre	ed at the	time, date opinion, o	and plac	e, end du urred at t	ue to the ca he time, da	use(s) a e and p	nd manner a	as starte	ed cause(s)
r s F ö	Me	29b Signature and	title of certific						29c	. License i	number			29d.	Date signe	d (Mon	th, Day, Y	ear)
		30. Name and addr	me ll	, Ki	م کھ	R, me	بي.			O.C.M	.E.			Oc	tober 16,	2006		
		Theodore M	1. King, Jr.			ant Medica	,	iner 1	111 Pe	nn Stre	et, Balti	imore,	MD 2120	01				
St	ate	31. Date filed (Mon.	th, Day Year)	3 21	32. R	egistrar's Sign	ature	1	nasti	3 9								

06-08082 Sheridan Spence

Please Type or Print in Black Indelible Ink

eridan Spence	1	State of Maryland /		rtment of			Mental	Hygie		1. No. 2 (1	06	3501
Physicia edical Examin	n/	Registrar 1. Decedent's Name (First, Middle,Last) Sheridan		Spen				Mr	ite of Death	Day Year	3.	Time of Death 1145 hrs
Carcar Examin		4a. Facility Name (if not institution, give street and number)					ocation of D		lober 21	4c. County of	Death	
Funeral	4	807 Benninghaus Road 5. Social Security Number 6. Sex 7. Age	(In yrs. la	ast birthday)		r 1 Year	If Under 2	4Hrs. 8. I	Date of Birth	(MM/DD/YYYY)		lace (State or
Director		215-34-8034 1XM 2 F	69	Yrs.	Months	Days	Hours	Min.	3-21-	1937	Foreign Count	ry) Va.
ny	F	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location	n						1/	Od. Inside City Limits
und show a	٦	Md. NA		Baltim	ore						1	Yes 2 No
Maryla r 28a-f	Director	10e. Street and Number			10f. Zip		10		10	g. Citizen of Wha		P
vith the Maryland ms 23a or 28a-fshow any be notified at once.		807 Benninghaus Road 11. Marital Status 12. Was Decedent	Ever in U				anic Origin?				America	n Indian, Black,
or item	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2	X No				Mexican, Pu	uerto Ricar	n, etc.)	White,		-1-
urs after tural",	اھ	3 Widowed 4 X Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade com	pleted)	16a. Decedent	's Usual		n (Give kin		lone	Specify: 16b. Kind of Busi	Blac ness/Ind	
336 thin 72 hours 2 ne. than "natura tedical Exami	Sete.	Elementary/Secondary (0-12) College (1-4 or 5	j+)			-	DO NOT us	e retired)		D	- M - E-	.u1
5-003 led withii Hygiene. other th	Completed	10th grade 17. Father's Name (First, Middle, Last)		Steel	. wor		8.Mother's N	Name (Firs	t, Middle, M	Raymon laiden Surname)	ia Me	eta1
ID 21215-0036 s should be filed within 72 and Mental Hygiene. 77 is marked other than matic event, the Medical	a	Anderson Frankli	n	Spend			Doro			Mae	Sper	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygicne. Int: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once	٩	19a. Informant's Name/Relationship (Type, Print) Jerome Spence Son								per, City or Town,		ip Code) 21214
Baltimore, MC permit. Pages 1 and 2 st Department of Health ar Important: If item 27 injury or other trauma		20a. Method of Disposition 1 Bunial 2 Cremation 3 Removal from Sta		Place of Dispositions or oth			etery,	Dat	е	20c. Location - 0	ity or To	own, State
Baltimore, permit. Pages 1 ar Department of Hee Important: If itel injury or other tr		4 Donation 5 Other Specify:	" Gı	reenmour				11–3–		Baltin	ore	Md
Balt permit. Depart Impor injury	1	21. Signature of Funeral Service Licensee				Address of No.	,			H. East timore,	Md.	21202
Physician /Medical		23a. Part I. Enter the disease, or complications that caused failure. List only one cause on each line.				of dying, s	such as card	liac or resp	iratory arre	est, shock, or hear	t	Approximate Interval Between Onset and
aminer		Immediate Cause (Final disease or condition resulting in death) a. Arteriosclerotic Due to (or as a conse			ase						_	Death
7	_	Sequentially list conditions, if any, leading to immediate b. Due to (or as a conse		off:							_	
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated									_	
executed an and al - transit	EX	events resulting in death) Last Due to (or as a const	,querioc e									
be exe	edical	UNPENDED AMENDED										
ox 68760, tath certificate be execut attending physician and for use as the burial - tra	sician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcor 1 Live birth			al death	3	Ectopic p	regnancy		23d. Date of d Month	lelivery Day	y Year
Box 6876 e death certificate the attending phy ed for use as the l	ysici	1 Yes 2 No 9 Unknown g Unknown	time of	5 Oth	ner (Spe	cify)						
s, P.O. Baires that the de signed by the I be detached is	by Phy	Part II. Other significant conditions contributing to deat	h but not r	resulting in the u	nderlying	cause gi	ven in Part		23e. Did tol			e cause of death?
w requires to been sign should be		Asthma						- 14	24a. Was a	an 24b. W	ere auto	psy findings available
ecor he law 1 ate has b	Completed							-	autops perfor 1 Yes 2		or to cor eath? Yes	mpletion of cause of
Vital Rec ysician: The his certificate I director, page	Be C	25. Was case referred to medical examiner? Hospital:		1		1/	of Death (C					
n of Vit ding Physic After this funeral dir	٤	1 Yes 2 No Indianal Inpatie 27. Manner of Death 28a. Date of Inj (Month, Day)	ent 2	ER/Outpatient 28b. Time of Ir		,OA	y at Work?	lursing Ho		Residence 6 🗸		Scene
sion of trending death.	ation	1 Natural 5 Pending 2 Accident Investigation (Month, Day,)	'ear)			1 Y	es 2 N	0				
Division of Vital Records, pital or Attending Physician: The law require ours after death. eral Director: After this certificate has been si filled in by the funeral director, page 2 should be	Certification:	3 Suicide 6 Could not be determined (Specify)	ıjury - At h	nome, farm, stree	et, factory	, office bu	uilding, etc.	28f.	Location (S or Town, St		or Rura	Route Number, City
E on bi		29a. Certifier (Check only 1 Certifying Physician: To the best of m										
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examiner stated. 29b. Signature and title of certifier	mination a	and/or investigat		y opinion, c. License		rred at the	time, date a	and place, and du		
d	=	7.ch=1110.A) \			O.C.N				October 27,		, ,
		30. Name and address of person who completed cause of a			n C4	of Delf:	more MA	24204	ndda.			
() S	ate	Zabiullah Ali, M.D. Assistant Medical E 31. Date filed (Month, Pay, Year) 32. Registra		- F	n Stree	ot, paill	more, ML	2 201			-	
Regis		NOV 0 3 2006	But I	1.50 /10 50	San Porch							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** MARY LOUISE SPIELMAN NOV. 2006 5:25 P ^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WESTMINSTER NURSING HOME WESTMINSTER CARROLL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 X F 67 Yrs 219-34-2134 2/27/1939 Director MARYLAND Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or items 23s or 28s-f show the Medical Examiner must be notified at WESTMINSTER Yes 2 No Completed by Funeral Director MD CARROLL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 30 LOCUST ST., APT. 402 21157 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify. 3 ☐ Widowed 4 ▼ Divorced WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) ould be filled within Mental Hygiene. other then Elementary/Secondary (0-12) College (1-4or 5+) LAUNDRY WORKER 10 HOSPITAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ie marked LAVERNE H. MILLER t and 2 should be Health and Ment tem 27 is marked HELEN E. ZEIGLER 2 19a. Informant's Name/Relationship (Type, Print) SON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MAURICE E. SPIELMAN, JR. 800 CHERRYTOWN RD., WESTMINSTER, MD 21158 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 = 5 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: if any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) PIPE CREEK CEMETERY 11/4/06 NEW WINDSOR, MD Signature of Funeral Service Licensee 22. Name and Address of FacilityFLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such appardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Priysician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-transit The law requires that the death certificate be executed Physician/Medical as IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de: 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ NO ŏ Month Day 4☐ Pregnant at time of death 5 Other (specify) P.O. signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ been sign 1 Yes 2 €10 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? page cate 1 ☐ Yes 2 ☐ No 1 Yes 2 1100 funeral director 25. Was case referred to medical certif Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending after deeth.

Director: Aft
I in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a To the Funerel D pelli 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai completely (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D25443 W. Mm 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 688 POOLE RD., WESTMINSTER, MD 21157 JOHN W. MIDDLETON MD 31. Date filed (Month, Day, Year) 32. Printer's Signature State NOV 03 2005 Registrar

		ľ	For State Registrar	State o	f Marylar				lealth a	and Me	ental Hy	gien Reg. N	7111	6	35018	
	Physicia	200	1. Decedent's Name (First, Middle, L	ast)							2. Date of De	ath Da	ay Y	'ear	3. Time of Death	
	Physicia /Medic	- 10	Mattie Irene								Oct. 31	1, 2	006		10:53 A ^M	_
	Examin	er	4a. Facility Name (If not institution, gi				,		Location o	of Death			County of			
		#F.	1601 N. Fountai 5. Social Security Number 6.	n Green	7. Age (In yrs.	last birthday)	If Under	Air 1 Year	If Under	24 Hrs.	8. Date of Bir		arfor		lace (State or Foreign	
	Funeral Director		578-42-3117	1□M 2K□F	78	Yrs.	Months		Hours	Min.	B. Date of Big (Month, Da June 9	y, Year.	28 1	Coun	land	
	P _		Usual Residence of Decedent			~			·							_
1	anyiar •how	7	10a. State 10b. County			ty, Town or Lo	cation							1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No	
3	ith the Marylar or 28a-f ehow	Director	Maryland Harfor 10e. Street and Number	:d	В	el Air	10f. Zip	Code				10a C	itizen of Wh	at Cour		
12	death with the Maryland ms 23a or 28a-f ehow prount be notified at		1601 N. Fountai	n Green	Road			015			İ	USA		at 0001	my:	
7	death ms 23	Funeral	11. Marital Status	12. Was Deci	edent Ever in U		Was Dece	dent of H	ispanic Orig	gin? (Spec	ofy Yes or No		14. Race -			
D.	after dea	Fū	1 Never Married 2 Married	Armed Fo	2 No	1	if Yes, spe 1 ☐ Yes		in, Mexican Specify:	i, Puerto H	(ican, etc.)			White,	etc.	
4.	72 hours "naturel", idical Exc	d by	3 🖾 Widowed 4 □ Divorced	Year or D	ates:								Specify:		nite	
S	within 72 hours after ene. than "naturel", or lite he Medical Exemina	lete	15. Decedent's l (Specify only highest g	Education rade completed)		16a. Dece (Give	dent's Usu kind of wo DO NOT u	rk done d	durina most	t of workin	g	16b. F	Kind of Busi	ness/Inc	dustry	
1 5	d withing giene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		ticia		_			Be	auty :	Salc	m	
	larylatto ZTZ 2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Ma	Be C	17. Father's Name (First, Middle, Las	st)		TAXA			18. Mothe	r's Name	(First, Middle				(4.1	
1 -	vuld be Wental Mental Irked o	To E	Dewey A. Douglas						Ethe	1 F.	Woodie	=				
	Fe, Marylaind ZIZIS-0050 s 1 and 2 should be filed within 72 hours after death with Health and Mental Hygiene. Health and Mental Hygiene is a sturiel; or items 23a o other traumatic event, the Madical Examinar must be other traumatic event.		19a. Informant's Name/Relationship			19b. Mailir	ng Address	(Street	and Numbe	r or Rural	Route Numb	er, City	or Town, St	ate, Zip	Code)	
	itam 27 other tra		Jane C. Sachs /N	iece	20h I	140 J	Jones	Spr	ing C		Road,		lerbe ocation - Ci		28338	_
12	Dallinore, permit. Pages 1 a Department of Hee Important: If itam any injury or othe once.		1 ☐ Burial 2 XCremation 3		State	cemetery, crei	matory or o	ther plac								
3	Dallimor permit. Pages Department of I Important: If itu any injury or of once.		4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice	- 41	Ні	lltop s							son, i	Mary	land	-
3	Depart Poerra		12. M/	le.							ne, P.A		n Ma	r:7] =	and 21009	
17	46		23a. Part1. Enter the disease, or conshock, or heart failure. List only	mplications that of	caused the deal						•		III I'III.	YIC	Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	Con	MADIA	011	0 0	de	Lsea	ر فحجه				>	Onset and Death	_
	/Medical		resulting in death)	Due to	(or as a consec	uence of):	7							1	x O grad	د.
	Examiner	_	Sequentially list conditions,	b	/											_
•	B C #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consec	quence or):										
	be executed icien and it	xar	that initiated events resulting in death) Last	c. Due to	(or as a consec	quence of):										-
9	ite be ex lysicien ne burial	cal		d.												
			IE EE MALE													
	S, F.O. DOX es that the death cer igned by the attendin be detached for use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1□Live b	tcome of pregnation	al death 3	Ectopic p	regnancy					23d. Date of		ory Day Year	
	the at	/slcl	1 Yes 2 No	4□Pregr 9□Unkn	nant at time of o own	death 5	Other (sp	ecify)					WOUT	'	Day 16ai	
à	that it	Ph)	Part II. Other significant conditions	contributing to d	eath but not res	sulting in the u	ndertvina o	ause give	en in Part I.		23e. Did	tobacco	use contrib	ute to th	ne cause of death?	
-	uires uires sign d be	d by	00. 1 0 -	ructiv	. 0.	eng (lie	as			1				ably 4 ☐Unknown	
	w requir s been si should	lete	rongestive	lea	it de	20:00	0)				24a. Was	an	24b. We	re auto	psy findings available	_
í	INISION OF VITAL RECORDS, P.O. BOX od or Attending Physicien: The law requires that the death certificate death. Director: After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the page of the	Completed by Physician/Med	. 0		7)						auto	psy ormed?	pridea	or to con ath?	npletion of cause of 2□No	
	ien: rtifice	Be C	25. Was case referred to medical						26. Place	of Death	(Check only			1165	20140	
3	hysic hysic his ce	ToE	examiner? 1 ☐ Yes 2 No		Inpatient 2	ER/Outpatier	nt 3 🗆 DC	Oth	өг. 4 □ Nu	rsing Hom	ne SRes	idence	6 Other	(Specif	1)	
	ing Pl		27. Manner of Death Natural 5 ☐ Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time o Injury		28c. Injun Worl	y at k?	2	8d. Describe					
:	Signature of the first of the f	Icat	2 Accident investigate 3 Suicide 6 Could not	be 200 Place	of laine. At h	10000 10000 11	M		Yes 2 🔲		Of Location	Ctrant a	ad Alumbus	or Pure	l Route Number.	_
	i or A after Direc	Certification:	4 Homicide determine	d 289. Flace build	of Injury - At h ing, etc. (Speci	fy)	reet, ractor	у, опісе		-	City or To			or mura	r Houte Number,	
	LIVISION ON VICE! The Investign Physicien: The law within 24 bouts after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier Certifying F	Physician: To the aminer: On the b	e best of my kno easis of examina	owledge, deat ation and/or in	h occurred vestigation	at the tin	ne, date an pinion, dea	d place, a	nd due to the d at the time,	cause(s	s) and mann nd place, and	er as si	ated. the cause(s)	_
	Fo the within Fo the	Me	29b. Signature and title of certifier						e number			29d. Da	ate signed (Month,	Day, Year)	
	1		1 mm	wmor	L. M.C)		Da	790	74			11-1	1-6	06	
	1		30. Name and address of person wh	o completed cau:			Print)	1 /	THS	RUI	LLS		M	\cap	21093	
		•	31. Date filed; (Month, Day, Year)	LLS /	Registrar's Sign:	ature		~ 0	, , , (1 L	4) (1101)	
	Sta Registr		NOV 0'3 Z00	S A Cas	3.0 A.S.	A STATE OF THE PARTY OF THE PAR	and the same									

		1 For		State	of Maryla		artment of H rtificate of I		Mental Hyg	iene 2006	35019
		_	estrar ent's Name (First, Midd	fle. Last)		Ce.	runcate or i	Jealii	2. Date of Deal	09.140.	3. Time of Death
	ician dical		rginia Lee	Stark					Month Atuh	Day Ye	2016 07:184
	niner	4a. Facili	y Name (If not institution	•	num <i>ber</i>)		1	Location of Death	1	4c. County of D	
.			09 Hillsid	e Drive	7. Age (In vi	s. last birthday)	Bel Ail	If Under 24 Hrs.	8. Date of Birth	Harfor	Birthplace (State or Foreign
Funer Direct			76-3742	1 □ M 2 2 F		,,	Months Days	Hours Min.	oct. 27	7, 1941	Country) Illinois
and		Usual Re	sidence of Decedent 10b. Count	y	10c.	City, Town or Lo	ocation				10d. Inside City Limits
Maryl -f sho	Į	Mars	land Harfo	rd		Bel Air					1 ☐ Yes 2 No
th the	Director	10e. Stre	et and Number	14		JOI 11112	10f. Zip Code		1	0g. Citizen of What	Country?
ath wi	jer		09 Hillsid				21014			USA	
filed within 72 hours after death with the Maryland Hygiane. Hygiane. Whysiene. Whysie	Funerai	11. Marii	al Status lever Married 2□ Ma	Armed	ecedent Ever in Forces? s 2 No		Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S) in, Mexican, Puert	pecify Yes or No- o Rican, etc.)		merican Indian, /hite, etc.
ours a	À	3 🗆	Vidowed 4 ☐ Divorce	If Yes,	Give r Dates:		1 ☐ Yes 2X No	Specify:		Specify:	White
swithin 72 ho piane. r then "natur	Pto			nt's Education est grade complete	ed)	(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of wor	king	16b. Kind of Busine	ess/Industry
y within	Completed	Eleme	ntary/Secondary (0-12)	College	e (1-4or 5+)		ice Worke	•		Food In	dustry
al Hyg	9		or's Name (First, Middle	, Last)						Maiden Surname)	-
should be nd Mental marked c	P	Ha	rold (nmn)						ouise Pl		
d 2 sh tth and 27 ts m			rmant's Name/Relation		istor		ing Address (Street: Alconbu			. ,	
s 1 and if Health Item 27		20a. Me	hod of Disposition		206	. Place of Dispo	osition (Name of matory or other place			20c. Location - City	
Pages ment of ent: # It			Burial 2 ☐ Cremation Donation 5 ☐ Other (Memorial (3-06 I	Bel Air,	Maryland
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiane. Important: If Hern 27 is marked other then may injury or other traumatic event, if when	once.	21. Sign	ature of Funeral Servic	e Licensee	1.	Ž	2 Name and Address MCCOMAS FI	ineral Ho	ome, P.A.	•	
		23a. Pa	nti. Enter the disease,	or complications the	at caused the de	eath. Do not en	1317 Coke: ter the mode of dyin	sbury Roa g, such as cardiac	or respiratory arr	gdon, Mar est,	yland 21009 Approximate
Physicia	an	Immedi	ock, or heart failure. Lis ite Cause (Final or condition			dun	6	4.00	, , +	,	Interval Between Onset and Death
/Medic Examin	al		in death)	Due	to (or as a cons	equence of):	known	fina	ry 7116		Lyeurs
X		Sequen	ially list conditions,	b. — Due	to (or as a cons	equence of):					
outed ansit	Fxaminer	cause. Cause (that initi	ially list conditions, ading to immediate Enter Underlying Disease or injury Ited events	1	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						
cate be executed physicien end sithe burial-transit			in death) Last	Due Due	to (or as a cons	equence of):					
icate b	ie			d							
n certif	n/Me	IF FEMA	LE: s decedent pregnant		outcome of pre					23d. Date of	delivery
es that the death certification of the death of the attending be detached for use as	Physician/Me	in 1	ne past 12 months? Yes 2 No	4□Pri	re birth 2 □ Fr egnant at time o nknown		☐Ectopic pregnancy ☐ Other (specify)			Month	Day Year
that the	P S		Unknown ` ther significant condi			resulting in the I	Inderlying cause giv	en in Part I	23e. Did to	hacco use contribut	e to the cause of death?
quires In signe		<u>د</u> ا	•			osaning in the	and onlying oddsoo giv	on 111 a.v. 1.	1 🗆 Y	A-/	Probably 4 Unknown
aw requi	Completed								24a. Was a	ın 24b. Wer	autopsy findings available
The lav	6	8							autops perfor	med? deat	to completion of cause of h? Yes 2 No
sician certific rector,	B.	25. Was	case referred to medic	Hospital:			at aci pos Oth	00	ith (Check only on		Luited
g Phys	F .		Yes 2 No ner of Death	28a. Da	ate of fnjury	☐ ER/Outpatie 28b. Time o	nt 3 DOA	4 Nursing H	ome 5 Reside	ence 6 AOther (: ow injury occurred	Specify) Living
ath.	<u></u>	1 X		tigation	fonth, Day Year,) Injury		K? Yes 2 □No			,
lor Att	Cortification.	3 <u> </u> 4 <u> </u>	Suicide 6 ☐ Coute Homicide deter	mined 288. Pl	ace of Injury - Auding, etc. (Spe	t home, farm, st ecify)	reet, factory, office		28f. Location (Si City or Town		r Rural Route Number,
To the Hospitel or Attending Physician: The law requires that the death certification to the Hospitel or Attending Physician: The law requires that the death certificate hes been signed by the attending is to the Furneral Director: After this certificate hes been signed by the attending is completely filled in by the funeral director, page 2 should be detached for use as	o leading		eck only 2 Medica	al Examiner: On th	the best of my lee basis of exam nanner stated.	(nowledge, deal ination and/or in	th occurred at the tin nvestigation, in my o	ne, date and place pinion, death occu	l n, and due to the c irred at the time, d	ause(s) and manne late and place, and	r as stated. due to the cause(s)
To th Withir To th	M		nature and title of certif	/			29c. Licens			29d. Date signed (M	
\cap			If ser	w, MD			715	3/4		dober	31, 2006
5		30. Nam	e and address of person Funkes	n who completed o	ause of death (I	tem 23a) (Type, / ロムパレモ	D15	vide 51	= Ikto	0 10	·
			1 - 1 - 1 . /		17	11 /		- / 5 //	1		
*	State istrar		filed (Month, Day, Yea	3 2006 32	2. Registrar's Sig	gnature	1			, ,	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 27, Physician Elizabeth M. Schuster 2006 4:45P M October 0 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Rockville Shady Grove Adventist Nursing Ctr. Montgomery 8. Date of Birth (Month, Day, Year) April 18, 1918 9. Birthplace (State or Foreign Country) Ohio **Funeral** Days 1 ☐ M 2 🟋 F 88 282-03-1378 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natura!" -- " any injury or other traumatic events. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Directo Montgomery Maryland Gaithersburg 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 104 Holmard Street 20878 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify ģ Specify: White 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Conley Mary Sasala ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Elizabeth Reilly / Daughter 104 Holmard Street, Gaithersburg, Maryland 20878 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium Inc. Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State November 4 □ Donation 5 □ Other (Specify) 2, 2006 | Bethesda, Maryland

iv Robert A. Pumphrey Funeral Home/ 22. Name and Address of Facility 21. Signature of Puneral Service Licensee M01433 Rockville, Inc. 300 West Rockville, Maryland 20814 Montgomery Avenue 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 18 Months Physician Colon Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Lisease of injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Vear in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 1 ☐ Yes 2 K No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑Unknown Stroke 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has le 2 autopsy performed? rector, page 2 death? 1 ☐ Yes Cardiomyopathy 2□ No 1 Yes 2 X No Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 ☐ Pending investigation Injury 1 X Natural 1 ☐ Yes 2 ☐ No ours after death.

neral Director: A
filled in by the fu 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide determined 29a. Certifier 1 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

within 24 hours a

10 State Registrar

15225 Shady Grove Road, #208, Rockville, Maryland 20850 Passi, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and little of certifier

29b. Signaturg

29c. License number

D28656

29d. Date signed (Month, Day, Year)

October 31, 2006

State of Maryland / Department of Health and Mental Hygiene 006 35021 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month 10 **Physician** 28 Leo E. Tamko 2006 10 40 AM /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Northwest Hospital Center Randallstown Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth Month, Day, Year) 7/13/1922 Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 X M 2 □ F 84 Yrs Director 154-16-7530 New Jersey Usual Residence of Decedent deeth with the Maryland 10c. City, Town or Location 10a State 10b. County 10d, Inside City Limits ?7 le marked other than "neturel", or iteme 23a or 28a-f ehow traumatic event, the Madical Examinar must be notified at 1 ☐ Yes XXNo Baltimore Reisterstown Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21136 12020 Reisterstown Rd. USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after Armed Forces?

Naves 2 □ No
If Yes, Give
Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: þ White Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Calendar Operator 10 Plastics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be unknown unknown 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrew Jordan - step son f Heelth 311 Lowell St. Apt. 3220 Andover, MA 01810 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State November Depertment of H Importent: If Ite eny Injury or ot once. cometery, crematory or other place)
Vincentown
Baptist Cem. XXBurial 2 Cremation 3 Removal from State **2,** 2006 Vincentown, NJ 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funery Service License 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services 8800 Harford Rd. Parkville, 21234 23a. Part / Inter the disease, or complications that caused the speck or heart failure. List only one druse on each line. that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Prysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter thickney ground Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 4☐Pregnant at time of death signed by the aid be detached for 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? leted by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si should I 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? s certificate has b lirector, page 2 s Compl autopsy performed? 1 Yes 2 No 1 Yes 2 No Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 2 1 Inpatient this Director: After th 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 5 Pending investigation Natural death. 1 Yes 2 No 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours e Cartifying Physician: To the best of my knowledge, death occurred at the time, date and Jane and due to the reuse(s) and tribuner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 28595 sneen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EILHIS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygie 10 6 35022 For State Registrar 1-Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death October **Physician** 755 DM THOMAS TANIE 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner NIA 7. Age (M yrs. last birthday) re BALTIMORE -UTure If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🔐 F 251-05-8372 89 Director Yrs NOVEMBER 3, 1916 S. CAROLINA Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Mudical Exactiner must be notified at 1 ✓ Yes 2 □ No MARYLAND TSALTIMORE Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? AVENUE DMONDSON 2122 U.S.A. 238 2503 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ☐ Yes 2 No f Yes, Give Year or Oates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 🗷 No Specify: BLACK þ 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) other then College (1-4or 5+) PRIVATE HOMES DomESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: if Item 27 is marked oth any lijury or other traumatic avant 2008. JACOB MARY MAGDALENE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (NIECE) 2503 EDMONDSON AVE, BALTIMURE, MD 21223 CARRIE JONES 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State LOVDON PARK CEMETERS 11-06-2006 BALTIMORE, MAKYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 2140 N. Fulton Avenue 3altimore MD. 21. Signature et Funeral Service Licensee whams Joseph H. Brown Jr. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Litter to control Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 | Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an autopsy performed? 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death | Check only one Hospital: Other: 2 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred After s efter des. rel Director: Atte 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospitel within 24 hours e To the Funerel C the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print). N Eulaw 221 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2006 Registrar

•	-	- chem	_	-	_
	9		\cap	2	2
	.)	. 1	1 1	/	.)
	\circ	~	0	_	_

			1 - For State Registrar			d / Depa		Health and I Death	•			35023
	Physici /Medi		1. Decedent's Name (First, Middle, Las Dawmya N.						2. Date of D Month Octobe	Day	2006	3. Time of Death 2:15 A ^M
	Examir		4a. Facility Name (If not institution, give Shady Grove Adve		-	L		or Location of Death	n	4c. Cou	nty of Deat	
Ī	Funeral Director		Social Security Number 6. S		Age (In yrs. Id			If Under 24 Hrs.	8. Date of B (Month, D June 2	irth (ay, Year) (4, 1945	_	nplace (State or Foreign
	e Maryland 8a-f ehow	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Montgome	ery	1	Town or Lo	rsburg					10d. Inside City Limits 1 X Yes 2 ☐ No
	with the	Dire	10e. Street and Number 7531 Laytonia Dr:	ive			10f. Zip Code	877		10g. Citizen Burma	of What Co	untry?
980	ges 1 end 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. If item 27 is marked other then "naturel", or items 23a or 28a-1 show or other treumatic event, the Medical Evantian must be notified at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Forces 1 ∐Yes 2 ☑ If Yes, Give Year or Dates	? No			Hispanic Origin? (S pan, Mexican, Puert	pecify Yes or No Rican, etc.)	lo- 14. F	llack, White	rican Indian, a, etc. :ian
21215-0036	within 72 ho ane. then "natu: 'e Medical	mpletec	15. Decedent's Ed (Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4o	r 5+)	(Give life.	dent's Usual Occu kind of work done DO NOT use retire ty Direc	during most of wor ad)	king	16b. Kind of		Industry
Maryland 2	2 should be fitted withir and Mental Hygiene. ie marked other then eurnatic event, tra Ms	To Be Co	17. Father's Name (First, Middle, Last) Umya Thaung	4		рери	ty Direc	18. Mother's Nan	ne (First, Middl vein Nye	e, Maiden Sum		
	end 2 should leafth and Men n 27 is marks ier treumatic		19a. Informant's Name/Relationship (7 Ukyaw M. Oo/Husba			7531	Laytonia					ip Code) and 20877
Baltimore,	permit. Pages 1 end 2 Department of Health a Important: if item 27 is eny injury or other tre ance.		20a. Method of Disposition 1 ☐ Burial 2 【X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify)		gomery (sition (Name of matory or other pla Crematorium	n, Inc. 200	-	Bethes	da, M	aryland
Ball	Depart Depart Import eny in		21. Signature of Funeral Service Licen: Magelatta Curra	ust	M013			ess of Facility Inphrey Fune teomery Ave			e, Inc aryl <i>a</i> n	d 20850
	Physician /Medical		23a. Part. Enter the disease, or comp shock, by heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	one cause on each a. <u>Myocar</u>	line.	Infarc		ng, such as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death Hours
8	Examiner		Sequentially list conditions,	b. Pulmon	ary Er							Hours
300	executed en and rial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Uncont		d Diab	etes					Years
68760,	icate be physicia s the bu	dlcal		d					-			
P.O. Box (The law requires thet the death certificate be executed has been signed by the attending physicien and page 2 should be detached for use as the buriat-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal	death 3	Ectopic pregnand Other (specify)	у			Date of deli Month	very Day Year
	w requires thet been signed b should be deta		Part II. Other significant conditions co Hypertriglycerider		but not resu	lting in the u	nderlying cause gr	ven in Part I.		tobacco use co		the cause of death?
Division of Vital Records,	The faw recate has be page 2 sho	Completed by								s an 24 opsy ormed? 2 XX No	prior to death?	topsy findings available ompletion of cause of
Vita	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			lot	26. Place of Dea		- X		
of	a Physer this eral di	n: To	27. Manner of Death	28a. Date of In	iury	28b. Time o	3 DOA	4 Nursing H		how injury occ		ufy)
vision	Attending ar death. ector: Afte by the fund	Certification:	1 🕅 Natural 5	286. Place of I	njury - At ho	Injury me, farm, str		rk?]Yes 2□No	28f. Location	(Street and Nu		ral Route Number,
Ö	To the Hospital or Attending Physicien: within 24 hours elter death. To the Funeral Director: After this certification completely filled in by the funeral director,		29a. Certifier 1X Certifying Phy	/sician: To the bes	etc. (Specify	vledge, deat	occurred at the ti	me, date and place	and due to the	own, State) a cause(s) and	manner as	stated.
	o the Hithin 24 o the Fi	Medical	(Check only one) 2 Medical Exam	and manner	or examinati stated.	on and/or in	vestigation, in my		rrea at the time	, date and plac 29d. Date sig		
	⊢ 3 ⊢ ŏ		> Allanke	and	M.	D.		55051	+	Octob		

10 State Registrar

17519 Redland Road, Rockville, Maryland 20855 Attan Kasid, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

06-08162 Lee Torres Please Type or Print in Black Indelible Ink

ee rones		State of Maryland / L 1- For State Registrar	Certificate of			eg. No. 2006	35021
Physici Medical Exami	iner	1. Decedent's Name (First, Middle,Last) Let: Alejandro Torres			Date of Deat Month October 2		3 Time of Death 1610 hrs
		4a. Facility Name (if not institution, give street and number) Rt. 135 @ Upper Savage Wood Yard	4	b. City, Town, or Location of I Bloomington	Death	4c. County of Death Garrett	
Funeral Director		634-10-4736 1XM 2 F 29	In yrs last birthday) Yrs	If Under 1 Year If Under 2 Months Days Hours		th(MM/DD/YYYY) 9. Birt Foreigi Cou	
v any	1	Usual Residence of Decedent 10a. State 10b. County 10	Oc. City, Town or Location	on			10d Inside City Limits
yland n-f shov	io	Texas Hidalgo	San Juan	10f. Zip Code		0g Citizen of What Coun	1 X Yes 2 No
tth the Maryland 23a or 28a-f show any notified at once.	Dire	1924 Loma Vista		78589		U.S.A.	uyr
fter death with I", or items 2	y Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Evarmed Forces? 1 Yes 2 Married 15. Was Decedent Evarmed Forces? 1 Yes 2 Married 15. Was Decedent Evarmed Forces?	If Ye	s Decedent of Hispanic Origin es, specify Cuban, Mexican, P Yes 2 No specify	uerto Rican, etc.)	White, etc.	an Indian, Black,
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene item 27 is marked other than "natural", or items 23a or 28a-f she r traumatic event, the Medical Examiner must be notified at once	Completed by	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) College (1-4 or 5+)	eted) 16a. Decedent during mo	's Usual Occupation (Give kin ost of working life. DO NOT us Driver	nd of work done	16b. Kind of Business/Ir	
21215-0036 vuld be filed within 7 Mental Hygiene marked other than c event, the Medica	Be	17. Father's Name (First, Middle, Last) Bartolo Torres		Mari		Maiden Surname) men Costilla	a
MD 2 nd 2 shoul alth and M m 27 is m	7	19a Informant's Name/Relationship (Type, Print) Ana Lizette Torres (Wife)		Address (Street and Number Loma Vista, Sa			Zip Code)
nor ages ent of nt: If		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify	20b. Place of Disposition crematory or oth	tion (Name of cemetery,	Date	20c. Location - City or Donna, Tex	
Baltir permit. I Departme Importa		21 Fignature of Funeral Service Licensee	22 Ne Me 3]	ame and Address of Facility Emorial Funera 11 E. Expressw		n Juan, TX	78589
Physician /Medical		23a. Part I Enter the disease, or complications that caused the failure. List only one cause on each line.					Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a Multiple Injuries Due to (or as a consequence)	uence of):				Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Discass of injury that infinite cause)	uence of):				
ransit	I Exa	events resulting in death) Last Due to (or as a consequence of the co	ænce of).				
760, Consider the content of the physician and the burial - transit	Medical	UNPENDED AMENDED					
lox 68 eath certif attending for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown	2 Fet	al death 3 Ectopic p	regnancy	23d. Date of delivery Month D	ay Year
, P.O. E ires that the d signed by the be detached	by Ph	Part II. Other significant conditions contributing to death be	ut not resulting in the u	nderlying cause given in Part		obacco use contribute to t	
cords, F law requires has been sign 2 should be	Completed b				24a Was autop		opsy findings available ompletion of cause of
tal Rec rian: The l certificate I		25 Was case referred to medical		26 Place of Death (C	1 Yes	2 No 1 Ye	2 No
of Vita ing Physici After this co funeral direc	To Be	examiner? 1 ✓ Yes 2 No Hospital 1 Inpatient			+	Residence 6 Other	Scene
ion o ttending leath tor: Afte		27. Manner of Death 1 Natural 5 Pending 2 ✓ Accident Investigation 28a. Date of Injury (Month DayYear Oct 29, 2006	28b. Time of Ir 1600 hrs	28c. Injury at Work? 1 ✓ Yes 2 N	Driver auto t	now injury occurred fixed object collisio	n
Division of Vital I Hospital or Attending Physician: 24 hours after death Funeral Director: After this certifi	Certification:	3 Suicide 6 Could not be determined (Specify) Major	r Road / Highway	et, factory, office building, etc.	Rt. 135 @ U	Jpper Savage Woo	d Yard, Bloomingt
To the Hos within 24 h To the Fun completely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated					
F 3 F 3	Me	29b. Signature and title of certifier		29c. License number O.C.M.E.		29d Date signed (Mon	
5		30. Name and address of person who completed cause of dea Zabiullah Ali, M.D. Assistant Medical Exal	,	n Street, Baltimore, MI	D 21201		
S Regis	tate	31. Date filed (Month, Day, Year) 2006 32. Registrar's	Signature				

			1 - For State Registrar	State of Ma	aryland / I	Department of Certificate o		Mental Hyg	giene 	35025
	Physici		Decedent's Name (First, Middle, Last ASYA)		TURETSKY		2. Date of Dear Month OCTOBER	Day Year	3. Time of Death 4:30 P M
1	/Medic Examin		4a. Facility Name (If not institution, give	street and number)			, or Location of Death		4c. County of De	1
			3 RUSSERN COURT A				IMORE			ΓIMORE
	Funeral Director		5. Social Security Number 6. Se 218–96–7357	x 7. Age	76	rthday) If Under 1 Yes Months Day		8. Date of Birth (Month, Day 03/23/1	9. Bi 930	rthplace (State or Foreign Country) KIEV
	yland		10a. State 10b. County		10c. City, Tow	n or Location				10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f ahow mat te multied at	Director	MD BALTIM	DRE	BALT	IMORE				1 Tyes 2 No
	with the	Dire	10e. Street and Number			10f. Zip Code		1	10g. Citizen of What C	Country?
	ns 23	Funeral	3 RUSSERN COURT A	12. Was Decedent B	Ever in U.S.	21215		pecify Yes or No-	U.S.A.	nerican Indian.
2-0036	a within 72 hours after death with the Marylan liene. r than "natural", or items 23a or 28e-f ahow the Medical Exercitor must be notified at	by	1 ☐ Never Married 2 ☑ Married . X X 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give X Year or Dates:	lo	If Yes, specify C	of Hispanic Origin? (Suban, Mexican, Puert Bo Specify:	o Rican, etc.)		ite, etc. HITE
2	72 ho	Completed	15. Decedent's Edu (Specify only highest grad		16a	Decedent's Usual Occ (Give kind of work don	ne during most of wor	rking	16b. Kind of Busines	s/Industry
7	within ene.	Jung	Elementary/Secondary (0-12)	College (1-4or 5	+)	ASSEMBLER	red)		EL ECT	RONICS
0	i Hygi other	Be Co	17. Father's Name (First, Middle, Last)	•		ASSEMBLER	18. Mother's Nan	ne (First, Middle, i		KUNICS
/Iar	Menta Menta arked artic av	To B	MICHAEL		GOROI	KH0VSKY	SONYA		SHER	BAKOVA
, Mar	s 1 and 2 shoul f Health and M Itam 27 is marl other traumati		19a. Informant's Name/Relationship (T) BORIS TURETSKY / I		3	RUSSERN CO	URT APT.			
sarimore	permit. Pages 1 Department of He importent: if Ita- any injury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		ARLING	t Disposition (Name of TON CHIZUK AMUNO CONG.	11/0	2/2006	BALTIMORE,	, MD
Sail	Depart Mport Mny inj		21. Signature of Funeral Service Licens			22. Name and Add	dress of Facility SOI	LEVINSO	ON & BROS.	, INC.
	ST ST ST		23a. Part1. Enter the disease, or comp	700700000000000000000000000000000000000	the death. Do				IKESVILLE,	MD 21208 Approximate
	Physician	5 9	shock, or heart failure. List only o Immediate Cause (Final	ne cause on each lin	10.					Interval Between
35	/Medical		disease or condition resulting in death)	Due to (or as	a consequence	<u>ン14パリリみし</u> of):	(11124	RE (10)	///00/10	
	Examiner	_	Sequentially list conditions,	b	CORON	ARDIAL Of): JARY AR: Of):	tery bi	SEASE		
ī	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequence	ERLIPEDE	MiA			
ב ב	iificate be executed g physicien and as the burial-transit	Exar	that initiated events resulting in death) Last	Due to (or as	a consequence	of):	(/)			
09/90	ate be nysicie he bu	edlcai	(d						
Ξ.	₹ 07 es		IF FEMALE:	20. #						
O. BOX	The law requires that the death certific 11e has been signed by the attending p 2ge 2 should be detached for use as	Physiclan/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 ☐ Ectopic pregnar 5 ☐ Other (specify)			23d. Date of do Month	elivery Day Year
7	s that ined b e deta	by Pt	Part II. Other significant conditions co		at not resulting i	n the underlying cause	given in Part I.	23e. Did tol	bacco use contribute	to the cause of death?
ecords,	equire ien sig ould b	ted t	HYPERTENSI) M				1 □ Ye	es 2 No 3□F	Probably 4 Unknown
ecc	faw nas be	Completed						24a. Was a autops	sy prior to	autopsy findings available ocompletion of cause of
<u></u>								perform 1 ☐ Yes		s 2X7No
VII	siciar certif recto	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:			2.1	th Check only on		
5	g Phy er this eral d	Η.	27. Manner of Death	1 Inpatie	y 28b.	Time of 28c. In	4 Nuising H		ence 6 Other (Sp ow injury occurred	ecify)
0	anding ath. or: Aftu	atlo	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	rear)		/ork? ☐ Yes 2 ☐ No			
DIVISION OF	or Atter or atter or acter or by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Ptace of Injubulding, etc	ury - At home, fa c. (Specify)	arm, street, factory, offic	ee .	28f. Location (SI City or Town	treet and Number or F n, State)	Rural Route Number,
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director.	cal	29a. Certifier (Check only one) 29a. Certifying Phy Certifying Phy Certifying Phy Description	sician: To the best of ner: On the basis of and manner sta	examination ar	e, death occurred at the	time, date and place y opinion, death occu	, and due to the carred at the time, d	ause(s) and manner a late and place, and du	as stated. re to the cause(s)
	To that within To the complé	Med	29b. Signature and title of certifier				nse number		9d. Date signed (Mor	•
	<		My fodo	7 . 1	MD	DY	0867		11/1/06	
	,		30. Name and address of person who come MIGUEL SADOV	NIK	1833	3 GREEN	TREE RO	1 . 3	PIKENILLE	MD 21298
	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 3 20		ar's Signature	South				
D. 1	. 41.47.0	201		The state of the s	-	and the same of th				

			Please T						Ensure A ealth and M					E026
			1 - For State Registrar	State 0	ı ıvıaı ylai	Cei	rtificate	of l	Death	nemai ny	Reg. No		0 3	5026
	Dhomisi		Decedent's Name (First, Middle, Last)	-				-		2. Date of D	eath		3. 1	Time of Death
	Physici /Medio		Nelson C. Wa							10	2.5 2.5		06 1	010A M
	Examin	er	4a. Facility Name (If not institution, give: Stella Maris				Tin	noni					timor	
	Funeral Director		5. Social Security Number 214-18-0262 Usual Residence of Decedent	X M 2□F	7. Age (In yrs.	. last birthday) 87 Yrs.	If Under		If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D 10/19	11 / 19	19 M	Country)	State or Foreign
	ed at	5	10a. State 10b. County MD Baltime	ore	10c. C	ity, Town or Lo	cation	^e						side City Limits
	with the N a or 28e-f	Direct	10e. Street and Number 4400 Marx Ave.				10f. Zip		n6		10g. Ci	tizen of Wha		
36	within 72 hours after death with the Maryland ene. then "natural", or Iteme 23a or 28e-f ehow ta Medicul Examinar must be notified at	by Funeral Director		12. Was Dece Armed Fo 1 X Yes If Yes, Gir Year or D	2 □ No ve			ent of Hi rfy Cuba	ispanic Origin? (Sp n, Mexican, Puerto	pecify Yes or N Rican, etc.)	0-	14. Race - A Black, V	American Inc White, etc. White	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. I Health and Mental Hygiene. Item 27 is marked other then "natural", or Iteme 23a or 28e-1 show other traumatic event. It a Medical Examination must be institled at	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation		(Give		k done d e retired	ation during most of work) cator	king		Soci	al	,
d 2	e filed at Hygie other	Be C	17. Father's Name (First, Middle, Last)						18. Mother's Nam	ne (First, Middle	e, Maider	Sumame)		
ylar	should be nd Mental n marked c	ToE	Dewey Walter						A	da Col	lie:	r		
Maryland	and 2 sho salth and n 27 ie m		19a. Informant's Name/Relationship (Ty Karen Wagner -	, . ,	hter				and Number or Ru. 1 $Ct.$	ral Route Numb Baltim				
Baltimore,	Pages 1 a lent of Hea nt: if item ry or othe	8	20a. Method of Disposition 18 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)		20b.	Place of Dispondent Ceme	sition (Name of the State of th	re of her place Fa.	th Nov	Date Dember 2006		ocation - City altim		
Balti	permit. Pages Department of I important: if ite eny injury or of		21. Signatur Fureral Service Licens	0 14	1	22	Name and	Addres	eral Charletion Se	-	8	800 н	arfoi	rd Rd.
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	COLOI Due to	Caused the dealeach line. N CANCE (or as a consection of the cons	R quence of):	er the mode	e of dyin	g, such as cardiac	or respiratory a	arrest,		Inter	roximate val Between et and Death
68760,	certificate be executed	edical	resulting in death) Last	Due to	(or as a conse	quence of):								
P.O. Box	death e atte d for	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ ∀es 2 □ No 9 □ Unknown	1☐Live t	tcome of pregribinth 2 Tet nant at time of lown	al death 3	Ectopic pre					23d. Date of Month	delivery Day	Year
	sign d be	۵	Part II. Other significant conditions col	ntributing to d	leath but not re	sulting in the u	nderlying ca	ause give	en in Part I.	1	tobacco Yes 2			use of death?
Il Records,	The law ete has b page 2 s	Completed					 			perf	opsy formed?	deat	e autopsy fir to completi h? Yes 2 !	ndings available ion of cause of No
Vital	Physicien: Th this certificete rai director, pag	Be	25. Was case referred to medical examiner?	lospital:				Oth	26. Place of Dea					
ot	Attending Physic death. ctor; After this by the funeral di	ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	10	Inpatient 2 of Injury oth, Day Year)	28b. Time of Injury		Bc. Injun	4 🗆 Nursing H	ome 5 Res			Specify) H	OSPICE
Division	2 4 2 5	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place build	e of Injury - At I ling, etc. <i>(Spec</i>	nome, farm, str ify)	reet, factory,	, office		28f. Location City or To			r Rural Rou	te Number,
	the Hoepital hin 24 hours a the Funeral I upletely filled	Medical (29a. Certifier 1 Certifying Phy (Check only one)	ner: On the b	e best of my kn basis of examin oner stated.	owledge, deat ation and/or in	h occurred a vestigation,	at the tin	ne, date and place pinion, death occu	, and due to the rred at the time	cause(s	and manne d place, and	r as stated. due to the o	cause(s)
)	To the To the comp	W	29b. Signature and title of certifier	7-					13725		29d. Da	ate signed (N	1 /	Year)
	441		30. Name and address of person who co	ompleted caus	se of death (Ite	т 23а) (Туре,						/		
	0		DR. TARIO MAHMOO	20.0	O DULAN Registrar's Sign	atura .			TIMONIUM,	MD 210	093			
6	Sta Registi			006	Togistrar's Sign	AR po	Joseph.	B						

Please Type or Print in Black Indelible Ink

gory A. vveis		1- For State Registrar	State of Maryland	Certificate o		d Mental I	, ,	eg. No. 2006	35027
Physicia dical Exami		Decedent's Name (First, M Gregory	iddle,Last) A.	Wels	h		2. Date of Dea Month October 3	Day Year	3. Time of Death 1831 hrs
		4a. Facility Name (if not institu			4b City, Town, or Baltimore	Location of Dea		4c. County of Death	L .
Funeral		5 Social Security Number	<u> </u>	e (In yrs. last birthday)	If Under 1 Year		_	th(MM/DD/YYYY) 9 Bir	
Director		216-08-0075 Usual Residence of Decedent	1 X M 2 F	32 Yr	Months Days	s Hours M	April	26,1974 Foreign	untry) MD
w any		10a State 10b. Cour	nty	10c City, Town or Loca					10d Inside City Limits
he Maryland 1 or 28a-f show a	Director	Maryland 10e. Street and Number	N/A 	Balti	More	_		0g. Citizen of What Cou	1 X Yes 2 No
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene in 12 hours after a filed with an "natural", or items 23a or 28a-f she unt: If item 27 is marked other than "natural", or items 23a or 28a-f she rother traumatic event, the Medical Examiner must be notified at once		6005 Marluth	Avenue		21206	<u>.</u>		USA	nu y :
r death wit or items 2 must be n	Funeral	11. Marital Status 1 XNever Married 2	Married 12. Was Decedent Armed Forces?	lf :	as Decedent of His Yes, specify Cuban	panic Origin? (: , Mexican, Puer	Specify Yes or No to Rican, etc.)	- 14. Race - Amer White, etc.	ican Indian, Black,
s after de ral", or	à		Divorced If Yes, Give Year or Dates:		Yes 2 No			ороспу.	nite
72 hours af n "natural" al Examin	eted	Elementary/Secondary (0-1	pecify only highest grade con College (1-4 or)	during r	nt's Usual Occupat nost of working life.			16b. Kind of Business/	Industry
215-0036 be filed within 72 ntal Hygiene ked other than ent, the Medical	Comple	12 years 17 Father's Name (First, Midd	dle, Last)	Move		18 Mother's Nan	ne (First Middle I	Moving and	Storage
1215 d be file lental Hy arked o	a	Robert Waymone	d Welsh Sr.			Susan	Ann Fett	weis	
b, MD 21215-0036 and 2 should be filed within 72 hours after teath and Mental Hygiene tem 27 is marked other than "natural", traumatic event, the Medical Examiner	٩	Robert W. Wel						nber, City or Town, State ore, Marylar	
Baltimore, MD 21215-0 permit Pages I and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked oth injury or other traumartic event, the h		20a. Method of Disposition 1 Burial 2 X Crema	tion 3 Removal from Sta		ther place)	Np.	venber 6,	20c. Location - City or	
Baltimore, permit Pages I ar Department of Hee Important: If ite		4 Donation 5 Other 21 Signature of Funeral Serv		Bayview (l l	006	Baltimore	
		23a yartyl. Enter the disease,	196/1					Dundalk, P. Dundalk,MD.	41444
Physician /Medical 5xaminer		fulure List only one cau Immediate Cause (Final disease	ise on ea fline.		the mode of dying,	such as cardiac	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
-xammer		or condition resulting in death		equence of):					
	iner	Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cau	Due to (or as a conse	equence of):					
ted Insit	Examiner	(Disease or injury that initiate events resulting in death) La		equence of):					
60, sale be executed ohysician and he burial - transit	ledical	UNPENDED	AMENDED						
6.5 at 6.5	Σ	IF FEMALE: 23b, Was decedent pregnant in past 12 months?	23c. If yes, outcomen the 1 Live birth		etal death 3	Ectopic pregr	nancy	23d. Date of delivery) Day Year
Box 687 e death certific the attending p ed for use as th	hysician/		Jnknown 9 Unknown	time of death 5 0	ther (Specify)			0.00	
ires that the designed by the signed by the less that the less signed by the less signed s	by Ph	Part II. Other significant con	ditions contributing to death	n but not resulting in the	underlying cause g	iven in Part I.		bacco use contribute to	
- 90 50 9	ompleted		-				24a. Was a		topsy findings available
Recol The law cate has page 2 sh	omo	-					autop perfor 1 V Yes	med? death?	ompletion of cause of
Vital Recysician: The his certificate director, page	Be C	25. Was case referred to med examiner?	Haspital	int 2 ✓ ER/Outpatien		of Death (Check			
n of V ling Phy After thi funeral d	2	1 Yes 2 No 27. Manner of Death	28a Date of Inju	rv 28b Time of		y at Work?	28d Describe h	Residence 6 Other	·
Division of Vital Records, rat or Attending Physician: The law requirers after death all Director: After this certificate has been sited in by the funeral director, page 2 should be	icatio	2 Accident In	vestigation Oct 31, 2006	FOUND: 1751 hrs jury - At home, farm, stre		es 2 V No	Subject was	treet and Number or Ru	rol Douts Number Ch
Div Hospital or 24 hours aft Funeral Di	Certification	4 V Homicide de	etermined (Specify) Loc			anding, oto.	or Town, S		lai Noute Number, City
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certifi completely filled in by the funeral director.	dical		Physician: To the best of my xaminer: On the basis of exam						
5 × 5 0	₩.	29b. Signature and title of cert	and manner stated		29c License			29d. Date signed (Mor	nth, Day, Year)
3		30. Name and a 1 ss of pers	thall, nul	eath (Item 23a)	0.C.N	Л.Е <i>.</i>		November 1, 200	6
), is	Pamela E. Southall,	MD Assistant Medi	cal Examiner 11	1 Penn Street	, Baltimore,	MD 21201		
St Regist	ate rar	31. Date filed (Month, Pay Yea	3 2008 32. Registral	r's Signature	Contis				
			3	W 14					

0	E	\cap	0	C
J	J	U	6	C

State of Maryland / Department of Health and Mental Hygiene UU 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 26, 2006 3:20 PM M Berkley Williams October /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 2725 Walbrook Avenue Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Hours 1 X M 2 □ F Director Jan. 10 Usual Residence of Decedent within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r then "natural", or Iteme 23e or 28e-f ehow the Medical Examiner must be notified at 1 Yes 2 □ No Director mor 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7*2* Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 M No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced Slac 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. important: if item 27 ie marked other then eny injury or other traumatic more. Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel-N.J d 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame Be 19a. Informant's Name/R lationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) L. Street Wa llams Shington Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Lattion - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10 n 21. Signature of Funeral Service/Licensee 22. Name and Address of Facility Home P. A to. Md. 21 h Li Russ Joseph Ave. Barto Enter the difease, or complications that cabe c, or heart failure. List only one cause on each 23a. Part 1 Enter the dis shock, or heart fail Immediate Cause (Final disease or condition sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, h line. Approximate Interval Between Onset and Death **Physician** VILGLES resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): P.O. Box 68760, the attending physicien Physician/Medical SON SOS use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ been signated 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s certificate has autopsy performed 1 ☐ Yes 2 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient Certification: To 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending To the Hospital or Attendir within 24 hours effer death. To the Funaral Director: At completely filled in by the fu death. investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the cauce(e) and maker as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30115 21215 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 26 OD LISE HY Herrs AYE BAIT MOK 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 3 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiefie 0.6

			1 - Registrar Amend Items 18,25,27,27,28a - f per	FH/ME 686111/02/06d	ABO. No.
	Physici	an	1. Decedent's Name (First, Middle, Last) Laura A. Wright	2. Date of D Month	Day Year
	/Medic Examin	_		City, Town, or Location of Death	4c. County of Death
				BACTIMON C- Inder 1 Year If Under 24 Hrs. 8, Date of B	N/A
*:	Funeral Director				Day, Year) Country)
	anyland show	_	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	the Marylar 28a-f ehow	ecto	10e. Street and Number	f. Zip Code	1 Stes 2 No 10g. Citizen of What Country?
	23a or	Funeral Director	6401 Loch Raven Blvd.	21239	USA
"	should be filed within 72 hours after dea na Menial Hyglene. marked other than "naturel", or freme imatic event, the Modical Examinating	Fune	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\subseteq \text{Never Married} \) 2 \(\subseteq \text{Married} \) 17 \(\text{Yes} \) 2 \(\subseteq \text{No} \)	Decedent of Hispanic Origin? (Specify Yes or Nosecify Cuban, Mexican, Puerto Rican, etc.)	No- 14. Race - American Indian, Black, White, etc.
5-0036	hours after turel', or Ite			es 2⊠No <i>Specify</i> :	Specify: Black
215-	in 72 h	Completed by	15. Decedent's Education (Specify only highest grade completed) (Give kind of life. DO No.	Usual Occupation of work done during most of working OT use retired)	16b. Kind of Business/Industry
212	ed within rgiene. er than "	Com	Elementary/Secondary (0-12) College (1-4or 5+)	aboner	National Box Co.
and	ould be file Mental Hy arked oth atic event	To Be (17. Father's Nargle (First, Middle, Last)	18. Mother's Name (First, Midd.	ah Clayton
Maryland	2 should and Me ie mark aumatic	ř		dress (Street and Number or Rural Route Num	
- 10	is 1 and 2 s of Health ar Item 27 is other trau			Westfield Avenue	
3altimore	ages 1 nt of H t: If Ite / or ot		20a. Method of Disposition 1	(Name of or other place) 1emorial 10/14/06	20c. Location - City or Town, State Raltman MA
altin	permit. Pages Depertment of Important: If I eny Injury or o		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Nan	ne and Address of Facility	Dulling MID
ä	Depermine the permine the perm			and Address of Facility Jun C. Gneene Funera Jyork Road Baltimor	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Immediate Cause (Final		Interval Between Onset and Death
8	Physician /Medical		disease or condition resulting in death) Due to (or as a consequence of):	ERNIATION OF	2 AIN
	Examiner	_	Sequentially list conditions b. SUBDURM 17	EMATOMA A	,
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	///	
oʻ	an and rial-tra				/
68760,	rificate be executed ng physician and as the burial-transit	edicai	d	CERTIFICATION APPROVED BY MED	ICAL EXAMINER
Вох 6	= 0 a	~	15 55 444 5	CERTIFICATION APPROVED	23d. Date of delivery
P.O. B	res that the death cer igned by the attendir be detached for use	Completed by Physician/N	in the past 12 months? 1 Yes 2 No 9 Unknown	pic pregnancy or (specify)	Month Day Year
	s that I	y Ph	Part II. Other significant conditions contributing to death but not resulting in the underly	ring cause given in Part I. 23e. Dic	tobacco use contribute to the cause of death?
ord	w requires been sign should be	ted t	CONGESTIVE HEART FAILURE.	10	Yes 2 No 3 Probably 4 Unknown
Division of Vital Records,	has he 2	mpie	SKK SINUS SYNDROME	per	opsy prior to completion of cause of death?
ital	yslcian: Th is certificate director, pag	Be Co	25. Was case referred to medical	1 ☐ Yes 26. Place of Death <i>Check only</i>	2 No 1 Yes 2 No
of V	d is	ပ္	1 XYes ZOLVO Hospital: 1 patient 2 ER/Outpatient 3	DOA Other: 4 Nursing Home 5 Re	
on	nding ith. : After e funer	ition	27. Manneyof Death Yamal Sample Pending 28a. Date of Injury 28b. Time of Injury	Work?	bbable fall.
N N	r Atter ter dea rector	tifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	actory, office 28f. Location	(Street and Number or Rural Route Number,
	pital o ours aff eral Di filled ir	Cer	Nursing Home 29a. Certifier 1 Certifying Physician. To the best of my knowledge deam occur	6000 Be	Llona Avenue, Balto., MD
	To the Hospital or Attending Pr within 24 hours atter death. To the Funeral Director: After th completely filled in by the funeral	Medical Certification:	29a. Certifier (Check only one) Certifying Physician. To the best of my knowledge, death occur Check only one) Certifying Physician. To the best of my knowledge, death occur Check only one)	arred at the time, date and place, and due to the attenuation, in my opinion, death occurred at the time	e cause(s) and manner as stated. eta, date and place, and due to the cause(s)
	To the Comp	Σ		29c. License number	29d. Date signed (Month, Day, Year)
•	(a)		30 Name and address of dereships completed cause of death (flow 33e) (Time Bright)	200000009.	CC 1364 11 3006
_(30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAMARITAN HOSPITAN	BAZ TIMORE	-0, MV
	Sta Registi		31. Dale (iled (Month, Day Year) 32. Registrar's Signature		

06-08251 Antonio Williams

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 35030

		1- For State Registrar			C	ertific	ate of	Death			Re	eg. No.	000	, 0000
Physicia		Decedent's Name (First, M	ddle,Last)							2. Date of Deat	th	V	3. Time of Death
Medical Exami		Antonio					Will:	iams			Month October 3		Year	2300 hrs
		4a. Facility Name (if not institute John Hopkins Hosp		street and nu	umber)		41	o. City, Town, Baltimore	or Location	of Death			ity of Death	
Funeral		5. Social Security Number	6. Se:	x	7. Age (In yr	s. last birt	thday)	If Under 1 Y	ear If Und	der 24Hrs	B Date of Bir	th (MM/DD/YY		hplace (State or Foreign
Director		214-90-9776		M 2 F	32	2	Yrs.	Months D	ays Hou	rs Min.	08–23	-1974	Cou	Md.
ŕ	- }	Usual Residence of Deceden 10a, State 10b, Cour			10c. C	ity. Town	or Location	on .				-		10d Inside City Limits
ow. al	- 1		•	a										1 Yes 2 No
Varyland 28a-f show any <u>d at once.</u>	ģ	Md. Ha 10e. Street and Number	rford	<u>ــــــــــــــــــــــــــــــــــــ</u>		AL	ingd	10f. Zip Code			I 1	0g Citizen of	What Cour	
e Mar or 288	Director										,	-		10 y :
ith the Maryland 23a or 28a-f sho		3725 Trailw	50a (cedent Ever i	- II C	12 10/00	2100		com2 / Cas	ecify Yes or No	USA		can Indian, Black,
215-0036 be filed within 72 hours after death with the Maryland nual Hygiene rked other than "natural", or items 23a or 28a-f shi ent, the Medical Examiner must be notified at once	Fune	11. Marital Status 1 Never Married 2 X 3 Widowed 4		Armed F 1 Yes If Yes, Give Yes	orces?		If Ye	es, specify Cut	oan, Mexica	n, Puerto F			hite, etc.	ack
hours al "natural"	d by	15. Decedent's Education (S	pecify on	or Dates: ly highest gra	de completed			s Usual Occu				16b. Kind of	Business/I	ndustry
72 ho	ete	Elementary/Secondary (0-	2)	College (1-4 or 5+)		during mo	st of working	ite. DO NO	I use retire	ea)			
5-0036 led within 72 hours after dygiene other than "natural", the Medical Examiner	ompleted	12th grade		2 yı	cs.		Unem	ployed				NA		
5-003 fled withi Hygiene Jother th	O	17 Father's Name (First, Mid Marcell Wil		•					18.Moth		(First, Middle, Mestine		_{me)} McBri	do.
21215-0036 Juld be filed within 7 Mental Hygiene marked other than	Be	19a. Informant's Name/Relati				140	h Mailine	Address (C	an at an at Ni		ural Route Nun			
E sid S	٢	Stacy Willia			ife		37	25 Tra:	ilwood		, Abing	don, M	ld. 2	1009
re, ME 1 and 2 sl ? Health ar f item 27		20a. Method of Disposition 1 X Burial 2 Crema	tion 3	Removal f			of Dispositions of Disposition	tion (Name of er place)	cemetery,		Date	20c. Location	on - City or	Town, State
MO Pages tent of		4 Donation 5 Other	-	Keliloval I	TOTTI OTATE	Kir	ng Mei	m. Pk.		11-	4 - 06	Randa	llsto	wn, Md.
Baltimore, permit Pages 1 a Department of He Important: If ite		21. Signature of Funeral Serv			-	_		ame and Addr			arch F. , Balti			21202
Physician	-	23a Part I Enter the disease	or omp		caused the de									Approximate Interval
/Medical		failure. List only one ca	ise on ea						0.					Between Onset and Death
∓xaminer	ш	Immediate Cause (Final dise or condition resulting in deat		Due to (or as										
N		Sequentially list conditions,	b.											
	ner	if any, leading to immediate cause. Enter Underlying Car	ise	Due to (or as	a consequen	ce of).								
	Examiner	(Disease or injury that initiate events resulting in death) La	d C.	Due to (or as	a consequen	ce of):								
760, ficate be executed g physician and the burial - transit			d.											
be exection a	n/Medical	UNPENDED		AMENDED										
8760, tificate be ng physic as the buri	/Me	IF FEMALE: 23b Was decedent pregnant	n the		outcome of p				o				e of delivery	
68 certifi	ian	past 12 months?		1 Live	nant at time o	F .1 11.	Fet	al death ner (Specify)	3 Ector	pic pregnar	псу	Monti	n L	Day Year
Box 68 e death cerri the attendin	Physicia	1 Yes 2 No 9	Unknown		nown		3 011	lei (opecity)						
at the d		Part II. Other significant co	ditions	contributing t	to death but r	not resultir	ng in the u	nderlying caus	e given in l	Part I.	23e. Did to	obacco use co	ontribute to	the cause of death?
, P.(res tha signed be det	d by										1 Yes	s 2 🗸 No	3 Prob	bably 4 Unknown
ords, v requires s been should	Completed	77.									24a Was autop			topsy findings available completion of cause of
eco eclaw te has	ф								-			rmed?	death?	
tal Rec		25. Was case referred to me	lical					26.PI	ace of Deat	h (Check c				
Vital ysician: his certif director,	o Be	examiner?	F	Hospital: 1	Inpatient 2	ER/C	Outpatient	3 DOA	Other ₄	Nursing	Home 5	Residence	6 🗸 Other	r Scene
Division of Vital Records, P.O. rate or Attending Physician: The law requires that the safer death and Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact	n: To	27. Manner of Death		28a Date	e of Injury th Day Year) , 2006		Time of Ir	njury 28c.	njury at Wo		28d. Describe Subject sho		curred	
ion tendi eath tor: /	atio		ending nvestigati		, 2006	195	0 hrs	1	Yes 2	✓ No	Jubject Sile			
ivisior or Attend after death Director:	Certification:	3 Suicide 6	could not	be 28e. Pla	ce of Injury -	At home, f	farm, stree	t, factory, office	e building,					ral Route Number, City
Di spital cours a reral I	Cert	4 Momicide	letermine	d (Specify) Local S	treet					Cator and 41	00 block Ell	kader Ave	nue, Baltimore, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	29a Certifier 1 Certifyin (Check only one) 2 Medical	g Physici Examine	r:On the basis	of examinati	wiedge, de on and/or	eath occur investigat	red at the time ion, in my opir	, date and plion, death	place, and occurred at	due to the caus t the time, date	se(s) and mar and place, ar	nner as star nd due to th	ted e cause(s)
To wit	Med	29b. Signature and title of ce	rtifier	and manner	stated			29c. Lic	ense numb	er		29d. Date s	signed (Mo	nth, Day, Year)
		(0)	DE) H	90 OC) a	e ~	0.	C.M.E.			Novemb	er 1, 200	06
		30 Name and address of pe	son who	completed car	use of death (Item 23a)								
8		Carol Allan, MD	Assista	int Medica	l Examine	r 111		Street, Balt	imore, M	ID 21201	1			
S Regis	tate	1341314	3	2000 32. F	Registrar's Sig	nature	A. Sanda							
			- W	1 4	W 11		- 100							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiere 0 0 6 35031 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Month 3. Time of Death Day Yeer 8:56 A M Bonnie Louise Wilson November 2006

deeth with the Maryland	23e or 28	rai Director	10e. Street and Nur		ia Road	1				p Code 2101	4			10g. Citizen of	What Co	ountry?
6		by Funeral	11. Marital Status 1 ☐ Never Marri 3 ☐ Widowed	_	ied 1 []	Decedent ed Forces? Yes 2 ☑ I s, Give or Dates:		.S. 13	. Was Dece If Yes, spe 1 \(\text{Yes} \)		lispanic Origi an, Mexican, Specify:	in? (Specify Puerto Rica	/ Yes or No- an, etc.)	14. Ra Bli Spec	ick, Whi	erican Indian, te, etc.
and 21215-0036	n "natur Medical	Completed	(Spec		st grade comple	eted) ege (1-4or 5	(A)	16a. Dec (Giv life	edent's Usu re kind of wi DO NOT I	al Occup ork done use retired	oation during most o d)	of working		16b. Kind of I		
25	ntal Hygiene. od other then event, the M		10						С	lerk		's Name (F	irst Middle	Grocer		
	d Mer nark natic	To Be	Harry (m	nn) Sou	ıth	n)		7 405 14-	**-	(2)	Magg	ie Io	uise	(unk)		
Mary Mary	alth and 27 is m r traum		Charles I			•								r, City or Town		zip Code) nd 21014
altimore,	ent of Heelth and Mer ht: If item 27 is marke ry or other traumatic		20a. Method of Disp 1 Burial 2 4	oosition Cremation	3 Removal		0	Place of Dispernetery, cr	oosition (Na ematory or	me of other plac	ce)	Date		20c. Location	- City or	Town, State
Balti	Department Important: If eny Injury o		21. Signature of Fu			/.	INOT	M	SCOMM.	y fu	Pk nerality	Home,	P. A	•		Maryland
			23a. Part1. Enter the shock, or head immediate Cause (complication only one cau e	hat caused on each lin		h. Do not e	nter the mo	de of dyin	ng, such as ca	ardiac or re	spiratory arr	on, Mar	yLar	Approximate Interval Between Onset and Death
	nysician Medical xaminer		disease or conditio resulting in death)	n	aDu	e to (or as		n65 uence of):	5	m p	H 450	EW H	to .			years
379 60,	icien and burial-transit	al Examiner	Sequentially list confrant, leading to im- cause. Enter Unde- Cause (Disease or that initiated events resulting in death) L	mediate irtying injury	c	e to (or as										
(DD303) 0. Box 687	by the ettending physicien and tached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1 □ Yes 2 9 □ Unknown	t pregnant months?	1 DL 4 DF	s, outcome ive birth Pregnant at Jnknown	2 Fetal	I death 3	□Ectopic p		,		-00-00F		ate of de	livery Day Year
Ords, P.O.	200	ρ	Part II. Other signif	2 1	tension		ut not resu	ulting in the	underlying	cause giv	en in Part I.		23e. Did to			o the cause of death?
Reco	2 (4	Completed										_	24a. Was a autop perfor 1 ☐ Yes	sy męd?	prior to death?	utopsy findings available completion of cause of
Vita	ector,	Be	25. Was case reference examiner?	red to medical	Hospitali					Tai		of Death C	heck only or			
on of o	h. After this c funeral di	tion: To	1 ☐ Yes 2 ☐ 27. Manner of Death 1 ☐ Natural	h 5 🗌 Pendin		1 ☐ Inpatie Date of Injur (Month, Day		ER/Outpate 28b. Time Injury		28c. Injur Wor	4 🗀 Nurs	28d.		lence 6 Ot ow injury occu		cify)
S ON Division	within 24 hours after death. To the Funerel Director: After this certificate he completely filled in by the funeral difector, page	Certification:	2 Accident 3 Suicide 4 Homicide	investig 6 Could r determ	not be 28e. F	Place of Injudicing	ury - At ho c. (Specify	ome, farm, s			162 5 140		Location (S City or Tow	Street and Num n, State)	ber or Ri	ural Route Number,
Nospital	within 24 hours To the Funere completely fille	Medicai C	29a. Certifier (Chack only one)	1 Certifyin 2 Medicai	g Physician: T Examiner: On and	o the best of the basis of manner sta	examinat	wtedge, dea tion and/or	ath occurred nvestigation	at the tin	ne, date and pinion, death	place, and occurred a	due to the cat the time, o	cause(s) and m date and place	anner as and due	s stated. a to the cause(s)
	24 Fi	B		2 Medicai	Examiner: On i	ine pasis of	examinat	tion and/or	nvestigation	n, in my o	pinion, death	occurred a	at the time, o	date and place	and due	to the cause(s)

State Registrar

Physician

		1	For State of Maryland	I / Department of Health and Me Certificate of Death	ental Hygie Reg.	2000 33032	
	, As		Decedent's Name (First, Middle, Last)		. Date of Death	3. Time of Death	
8	Physici /Medio		EMILY DARA	WEINSTEIN	NOV EMBER	1 2006 12:01 A M	A
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
	<u> </u>	*	407 MARYLAND AVENUE 5. Social Security Number 6. Sex 7. Age (In yrs. Ia	CATONSVILLE ast hidhday) If Under 1 Year If Under 24 Hrs. 8	Date of Birth	BALTIMORE 9. Birthplace (State or Foreig	ממ
	Funeral Director		213-23-5888 ^{1□M 2} √√ F 17	Months Days Hours Min	2/25/1988	Country) MD	
-			Usuel Residence of Decedent	, Town or Location		10d. Inside City Limits	_
	laryla shov	ō		TONSVILLE		1 Tyes 2 No	
	the A	Director	10e. Street and Number	10NSVILLE 10f. Zip Code	10g.	Citizen of What Country?	
	h with		407 Maryland Avenue	21228		U.S.A.	
	ems :	Funeral	11. Marital Status 12. Was Decedent Ever in U.S	 Was Decedent of Hispanic Origin? (Speci If Yes, specify Cuban, Mexican, Puerto Ri 	ify Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc.	
36	be filed within 72 hours after death with the Maryland tal Hygjene. Id other then "natural", or items 23a or 28a-f show event, the Marylaal Examinar must be notified at	by Fu	1 Never Married 2 Married 1 Yes 2 No If Yes, Give X Year or Dates:	1 Yes 2 No Specify:		Specify: WHITE	
9	72 hours "natural", official Exe		15. Decedent's Education	16a. Decedent's Usual Occupation	168	p. Kind of Business/Industry	_
215	thin 7 e.	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of working life. DO NOT use retired)	,	NONE	
2	led wi tygien her th		0 17. Father's Name (First, Middle, Last)	NONE 18. Mother's Name (First Middle Mail	NONE	
anc	d be fi	o Be		EINSTEIN LOIS	r irst, renddio, rendr	CONN	
ary	should and Mer marks umatic	스	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural)			
Baltimore, Maryland 21215-0036	ss 1 and 2 should be filed within by Health and Mental Hygiene. If them 27 is marked other then other traumatic event, Ins. M.		FREDERICK WEINSTEIN/FATHER	16 PEBBLE LANE - TIMONI			
lore	Pages 1 nent of H int: ff iter iry or oth		1 V Burial 2 Cremation 3 Removat from State	ace of Disposition (Name of Dai metery, crematory or other place)	1	c. Location - City or Town, State	
Ħ	permit. Pages Department of Important: If I any injury or one		4 Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licensee	IMORE HEBREW CONG. 11/02 22. Name and Address of Facility SOL			
Ba	Departition of the point of the		> Con Charles	8900 REISTERSTOWN RO			
			23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	. Do not enter the mode of dying, such as cardiac or	respiratory arrest.	Approximate Interval Between	
	Physician		Immediate/Cause (Final disease or condition	Infection		Onset and Death 5 days	
~	/Medical Examiner		Due to (or as a consequ			10	
	A.	er	Sequentially list conditions if any, leading to immediate cause. Enter Underlying	C Quadriplegia Syndrome		- diger	
	icate be executed physician and s the burial-transit	Examiner	that initiated events	Syndrome		17 year	3
,00	cate be executed obysician and the burial-transit		resulting in death) Last Due to (or as a consequ	ence 1):		V	
8760,	physic	dical	d				
9 xc	.Ξ Oπα	cian/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregna			23d. Date of delivery	
OLATIC SINK BOX	iaw requires that the death certifi as been signed by the attending p 2 should be detached for use as	sicia	in the past 12 months? 1 Yes 2 No 9 I blokes in the past 12 months?			Month Day Year	
P.O	d by the	Physi	9 □ Unknown	siting in the underhing cause guess in Part I	23e Did tohac	cco use contribute to the cause of death?	
- 30	signe d be d	by	Part II. Other significant conditions contributing to death but not resu	ining in the Globilying cause given in rait.		2 ₱€ No 3 Probably 4 Unknow	/Π
Zo	law requires as been sign 2 should be	Completed			24a. Was an	24b. Were autopsy findings available	le
D. B.	ilcian: The lav certificate has rector, page 2	ошр			autopsy performed 1 Yes 2 Z	prior to completion of cause of death? No 1 □ Yes 2 □ No	
7 ta	ian: ortifica ctor, p	Be C	25. Was case referred to medical examiner?	26. Place of Death			
243	Physician: this certific ral director,	은	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐			e 6 ☐Other (Specify)	
35	ding P	ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28b. Time of	3d. Describe how	injury occurred	
/isic	Atten r deat octor:	fica	3 Suicide 6 Could not be 28e. Place of Injury - At ho	me, farm, street, factory, office 28		et and Number or Rural Route Number,	
تِ قِ	tal or rs afte al Dir	Certification:	4 Homicide determined building, etc. (Specify		City or Town, S	State)	
XDU	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medicai	(Check only 2 Medical Examiner: On the basis of examinal	wledge, death occurred at the time, date and place, artion and/or investigation, in my opinion, death occurred	nd due to the caus d at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)	
A.	o the ithin 2 o the omplet	Med	one) and manner stated. 29b. Signature and title of certifier 7	29c. License number	29d	. Date signed (Month, Day, Year)	
	- 31-0		> GAN Bo Thurs - M.I.	00050714	No	ovember, 1, 2006	
	2		30 Name and address of person who completed cause of death (Item		1		
	0		and originally cons				
	St Regist	ate rar	31. Date filed (Month, Day/Year) 32. Registral's Signa	Jane Jane			
	MACS.		4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	- 1			_

State of Maryland / Department of Health and Mental Hygien & U U 5 For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** ESTELLA MAE (LLEWELLYN) BARCLAY 2059 10 06 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner WMHS-Braddock Campus Cumberland Allegany If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M X F 216-05-8954 90 Yrs MARYLAND MAY 6, Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow rthen "naturel", or items 23a or 28a-f ebov the Medical Examiner must be nutified at Yes 2 No MD ALLEGANY LONACONING Funeral Director 10e. Street and Number 38 WEST MAIN STREET 10g. Citizen of What Country? 10f. Zip Code 21539 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※ ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes X2 ☐ No Specify: Specify: WHITE Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) TEXTILE CONING DEPART permit. Pages 1 and 2 should be file Dapartment of Heelth and Mental Hy important: if item 27 is marked other eny injury or other treumatic event, once. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) FRANK H. LLEWELLYN IDA (MEASE) Llewellyn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Daughter-in-Darlene Barclay 12823 Meadow Ave, Cresaptown, MD 21502 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition X□ Burial 2 □ Cremation 3 □ Removal from State Nov 2 2006 | Frostburg, MD 21532 Frostburg Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hafer Funeral Service, PA 21. Signature of Funeral Service Licensee 1302 National, LaVale, MD 23a. Part LEnter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ling. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Mator **Physician** 1000 /Medical Due to (or as a consequence of) Examiner Nursing Home Acquired neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attanding physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4☐Pregnant at time of death 5 Other (specify) P.O. 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 5 nellitus; Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No 1 Yes 201 No 1 Tyes of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No To the Hospital or Attending Phys within 24 hours after death.

To the Funerel Director, After this completely filled in by the funeral dir 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No М 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Image: Continuous of the death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of certifier cons 110021488 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Devlis 20 Douslas MD homas 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar 2006

DHMH 17 Rev 1/2001

ORIGINAL

		1- State of Maryland / Department	artment of Health and M rtificate of Death	lental Hygier	ZIIII 351134
Physic		1. Decedent's Name (First, Middle, Last) Wennetta Blake		2. Date of Death Month OCTOber	3. Time of Death 1:05 A M
/Med Exam		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
*		9 Indian Rd.	North East		Cecil
Funera Directo		5. Social Security Number 6. Sex 1 M 2 XF 7. Age (In yrs. last birthday) 53 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth Month Day, Yea 8/2/1953	9. Birthplace (State or Foreign Country) South Carolina
aryland ehow	or .	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo MD Cecil North Ea			10d. Inside City Limits 1 ☐ Yes 2 💆 No
tha M 28a-f	rect	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Country?
3a or	D	9 Indian Road	21901		U.S.A.
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Plygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be natified at	y Funeral Director	Armed Forces? 1 □ Never Married 25 Married 1 □ Yes 21 No If Yes Give	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2X No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
hours tural;	ed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education 16a. Dece	dent's Usual Occupation	16b.	Kind of Business/Industry
Maryland 21215-0036 at 2 should be filed within 72 hours att the and Mental Hygiene. 27 Is marked other than "natural", or traumatic event, the Medical Exercitations.	Completed	(Specify only highest grade completed) (Give	kind of work done during most of work DO NOT use retired)	ing	Jursing
Hygir other		17. Father's Name (First, Middle, Last)		e (First, Middle, Maid	
vid be	To Be	Leon Ray Holaway	Tsuyako	Inagaki	
land land land land land land land land	1	N. Carlotte and Ca	ng Address (Street and Number or Run		
e, N 1 and 1 and 1 and 1 and 1 and 1 and 1 thar th		20b. Place of Disposition 20b. Place of Disposition	osition (Name of	East, MD	21901 Location - City or Town, State
agas int of h		cemetery, cre	matory or other place) Iem. Gdns. 11/2		erdeen, Maryland
Baltimore, permit. Pagas 1 ar Department of Healmportant: If item		21 5 unature of Funeral Service Licensee 2	2. Name and Address of Facility Tarring-Cargo Fund Aberdeen, Maryland		
	(23a, Part1. Enter the disease, or complications that caused the death. Do not en			Approximate Interval Between
Pnysicia: /Medica Examine	i	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	<u> </u>		Onset and Death
No.	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (brease or lightry that initiated events			
8760, cate be executed oblysician and the burial-transit	dical Exa	resulting in death) Last — Due to (or as a consequence of):			
O. Box 6 the death cartific y the attending p ched for use as	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
ds, P. uires that signed b	by	Part II. Other significant conditions contributing to death but not resulting in the of New York and its Breast Cam	underlying cause given in Part I.		co use contribute to the cause of death? 2
Vital Records, ician: The law requires the certificate has been signed ector, page 2 should be	Completed			24a. Was an autopsy performed 1 Yes 2 4	
	BeC	25. Was case referred to medical		h (Check only one)	
of Vita Physician: r this certific ral director,	12	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie			6 Other (Specify)
Jung After fune	ion:	27. Man Death 1 Natural 5 Death 1 Natural 5 Deading (Month, Day Year) Injury 2 Decident investigation	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred
Division To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)		28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
Hospita 24 hours 9 Funeral etely filled	edical C	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the cause red at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
To the within To the	Me		29c. License number	29d.	Date signed (Month, Day, Year)
		1 8/1 PHS/De	D35653	10)/30/06
7		30. Name and address of person who completed cause of death (Item 23a) (Type Martha Hosfard, MD III W	Print) High St Ste	104 EI	ton, MD 21921
Regi	state strar	31. Date filed (Month, Day, Year) NOV 0 3 2006	ade		

State of Maryland / Department of Health and Mental Hygien ? For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 2006 715 M Laura Virginia Beebe /Medical 4b. City Jown, or Location of Death County of Death Facility Name (If not institution, give street and number) Examiner at the lake licomico Hospice 115 oas tal ba If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☐ M 2 🔯 F Yrs. 161-20-0142 VA Director Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a State 10b County in then "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at XXYes 2 □ No Director Snow Hill MD Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 303 Belt St 21863 USA by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3K Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Flementary/Secondary (0-12) 9 Housewife Own Home ith and Mental Hygie 27 Is marked other r traumatic event, It 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be Anna Custis William Stewart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health it Elsie Ahmad (niece) 303 Belt St., Snow Hill, MD 21863 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Importent: If Ite eny Injury or oth once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/22/2006 Spence Baptist Cem. Snow Hill 4 □ Ronation 5 □ Other (Specify) 21. Signature of Funeral Ser 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, MD 21811 englism 1100284 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Clase (Final Cerebrovascula Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit To the Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death d. Date of deliver 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Year Month 4☐Pregnant at time of death 5 Other (specify) been signed by the s should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>^</u> Division of Vital Records, 1 ☐ Yes 2 ZNo 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has t irector, page 2 s director, 25. Was case referred to medical Be 26. Place of Death (Check only Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No ၉ 1 ☐ Yes 2 ☐ ER/Outpatient 3 ☐ DOA this After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: Natural 2 Accident 5 Pending within 24 hours after death.

To the Funstal Director: Ai
completely filled in by the fu 1 Yes 2 No investigation 3 ☐ Suicide 6 Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifie 26278 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BUX 1733 . (Discell Registrar's Signa State 2006 20

Registrar

			1 - For State Registrar	State of	Marylan		artmen rtificate				lental Hy	giene Reg. No.	006	35036	
	Physici		1. Decedent's Name (First, Middle, Charles Lee But								2. Date of Dea Month 10	Day	2006	3. Time of Death	
>	/Medic Examin Funeral Director		4a. Fecility Name (If not institution, give street and number)					4b. City, Town, or Location of Death					County of Deat		
			Ginger Cove Nursing 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,					Annapolis If Under 1 Year If Under 24 Hrs. 8, Date of Birth					Anne Arundel		
			553-54-2191	88		Months Days Hours Min.			8. Date of Birt (Month, Da 2 28	y, Year) 3 191	9. Birthplace (State or Fore Country) MD				
ryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-1 ehow eny injury or other traumatic event, the Madical Examinar must be notified at once.		Usual Residence of Decedent 10a, State 10b, County		10c. City	y, Town or Lo	ocation				***************************************			10d. Inside City Limits	
ы Ма		cto		Arundel	Anna	apolis								1 Yes 21 No	
with t		吉	10e. Street and Number	t. D									en of What Co	untry?	
leath		era	4228 River Creso	12. Was Dece		.S. 13.				igin? (Spi	ecify Yes or No	USA 1	4. Race - Ame	rican Indian,	
)36 urs after o		by Funeral Director	1 ☐ Never Married 2 ☐ Marrie	ces? 2 No 1936 tes: 197	U.S. 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:					Rican, etc.)	Black, White, etc. Specify: White				
5-0(eted	15. Decedent' (Specify only highest	s Education		16a. Dece	dent's Usua kind of wo	rk done a	lurina mos	t of work	ing	16b. Kin	d of Business/	Industry	
21215-0036 ad within 72 hours af		Completed	Elementary/Secondary (0-12)	College (1-	4or 5+)		Offi Offi)			Mili	tarv		
D 2		BeC	17. Father's Name (First, Middle, L	ast)		2.00.0	<u> </u>		18. Mothe	er's Name	e (First, Middle,			-	
ylar ould be		P V	Villiam Thomas Bu	_							Lee Bass				
Maryland			19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Ohanian (daughter) 6469 Lake Meadow Dr., Burke., VA 22015												
Baltimore,			20a. Method of Disposition 1 ☑Burial 2 ☐Cremation		State	Place of Dispo	matory or o	ther place			Date		ation - City or	Town, State	
altin			4 Donation 5 Other (Specify) Evergreen Cemetery 10/21/2006 Berlin MD 21. Signature of Funery Service Licensee 22. Name and Address of Facility The Burbage Funeral Home										Home		
6 8			108 William St., Berlin, MD 21811												
Ex	** Attending Prysicien: The law fequires that the death certifica for a feach. It for death. Iter death. Infector: After this certificate has been signed by the attending ph. In by the funeral director, page 2 should be deteched for use as th.	ner	23a. Paff. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Doath One source of the condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying												
68760, tilicate be executed		edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	or as a consequ	uence of):									
. Box		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \ Yes 2 \ No 9 \ Unknown \ Unknown \ 23c. If yes, outcome of pregnancy \ 1 \ Live birth 2 \ Fetal death 3 \ Ectopic part of the pregnant at time of death 5 \ Other (s						opic pregnancy er (specify)				23d. Date of delivery Month Day Year		
		Ď	Part II. Office significant continuous contributing to death out not resulting in the underlying cause given in Part I.									the cause of death?			
Division of Vital Records, I or Attending Physician: The law requires t		Completed				,, <u>, , , , , , , , , , , , , , , , , , </u>					24a. Was autor perfo 1 \(\text{Yes} \)	sy	24b. Were au prior to death?	topsy findings available completion of cause of	
/ita		Be	25. Was case referred to medical examiner?								of Death (Check only one)				
of Physic		٠ <u>.</u>	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other							A Ruising Forme 5 Hesidence 6 Other (Specify)					
ion		atlon	1 Autural 5 Pending	Injury	f 28c. Injury at 28d. Describe how injury occurred Work? M 1 Yes 2 No										
Divis		Certification:	3 Suicide 6 Could n 4 Homicide determi	nod 286. Place									ral Route Number,		
• Hospital		edical C	29a. Certifier (Check out) (Ch												
Toth		Me	29b. Signature and title of certifier Paul Berg mD 29c. License number 29d. Date signed (Month, Day, Year) 10/18/2006												
	41		30 Name and address of person v	who completed cause	e of seath (Item	n 23a) (Type,	Print)		4		· La E 4	-00	M	21114	
	Sta	ite	31. Date filed (Month, pay, Year)		gistrar's Signa	L // C	TYM	51	17 W	y, C	rut/	U//	, 1110	21114	
*	Regist		OCT 20	2006	an.	& A	soule	,							

		Í	1 - For State Registrar		larylan		artment tificate				Reg. No	2006	
	Physic	_	Decedent's Name (First, Middle, La Kathyrn	st) Δ		Brit	tingh	o.m.		2. Date of De Month	Da	y Year 9 200	3. Time of Death 6 0 820 M
)	/Medi Examir		4a. Fecility Name (If not institution, giv	e street and number)	DLII			Location of I			. County of Dea	th
			PENINSUM REGIONOS		1. 11	ntu		SAG	stilly			Hicom	100
2	Funeral Director		212-12-3135	ex	ge (In yrs. I	last birthday) Yrs.	If Under 1 Months	Year Days	Hours	Min. 8. Date of Bir (Month, Date of Bir 12-27-	th ly, Year) 1918		thplace (State or Foreign ountry) yland
,	and		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation						10d. Inside City Limits
	the Maryland	to	MD Wicomic	0	Sal:	isbury							M∑Yes 2 No
	with the a or 28a Lee noti	Director	10e. Street and Number				10f. Zip C	ode			10g. Ci	tizen of What Co	ountry?
	23a c		508 Dover Street				2	21804	4		USA		
75-77 15-0036	urs after death v al', or itema 23 exeminer unest	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 Yes 2X If Yes, Give Year or Dates:	?		Was Decede f Yes, specif 1 □ Yes 2/		panic Origin , Mexican, I Specify:	n? (Specify Yes or No Puerto Rican, etc.)	>-	14. Race - Ame Black, Whit Specify: W	
19.0	within 72 hours after ene. than "natural", or ite	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		5+)	(Give	dent's Usual kind of work DO NOT use	done di retired)	ıring most o	f working		and of Business	Vindustry
d 21	be filed with ttal Hygiene. Ind other than	ပိ	17. Father's Name (First, Middle, Last)		Nurs	ing As			Name (First, Middle		edical Sumame)	
lan	should be filed with and Mental Hygiene. Is marked other that aumatic event, the ta	To Be	Elmer W		Deni	nis]	Ruth	М.		Shor	tt
Maryland	es 1 and 2 should be filed within of Heelth and Mental Hygiene. I flem 27 is marked other than rother traumatic event, the Merican of the foother traumatic events and the foother events and the foothe		19a. Informant's Name/Relationship (Ronald Brittingha							RD, Snow			
Baltimore,	Pages 1 a ent of Her nt: If Item ry or othe		20a. Method of Disposition 1 ∑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Removal from State	C	lace of Dispo emetery, crer	sition (Name natory or oth	e of er place)	Date 0-23-2006	20c. L	ocation - City or	Town, State
Balti	permit. Pag Department Important: t eny injury o		21. Signature of Funeral Service Licer		ake	22	. Name and	Address	of Facility	Bounds Fun	eral	Home	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each	d the death	n. Do not ent	er the mode	of dying	, such as ca	rdiac or respiratory a	rrest,		Approximate Interval Between
	Physician /Medical Examiner prize and prize priz	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	s a consequence a consequence		, c	161	n m	onc			Onset and Death
8760,	ate be ex hysicien (the burial	dical	rosaning in doubly 2250	Due to (or as	s a consequ	uence of):							
P.O. Box 6	iaw requires that the death certificate be executed as been signed by tha attending physicien and 2 should be detached for use as the burial-transi	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 mopths? 1 □ Yes 2 ⊡ No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetel	Ideath 3	Ectopic pred Other (spec					23d. Date of de Month	livery Day Year
	quires that n signed build be deta	by	Part II. Other significant conditions	contributing to death	but not resu	ulting in the u	nderlying cau	use givei	n in Part I.			/	o the cause of death?
of Vital Records,	The law requir ate has been si page 2 should	Completed								24a. Was auto perfo	psy rmed?	death?	utopsy findings available completion of cause of
ita	ian: artifice ctor, p	Bec	25. Was case referred to medical examiner?				-		26. Place of	Death Check only			
n of V	ling Physician: n. Aftar this certific funeral director,	္	1 Yes 2 100 27. Manne Death 1 Natural 5 Pending	Hospital: 1 Impat 28a. Date of Inj (Month, D.	ury	ER/Outpatier 28b. Time of Injury		Other c. Injury Work	4 LINUIS	ing Home 5 Resi			ocify)
Division	or Attenction distribution of Attence death Sirector: in by the	Certification:	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of Ir	ijury - At ho tc. (Specify	ome, farm, str	M eet, factory,		es 2□No				ural Route Number,
_	Hospita 14 hours Funere tely fille	edical Ce	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Exam	nysician: To the besi niner: On the basis and manner s	of examinat	wledge, death tion and/or in	n occurred at vestigation, in	the time	e, date and p nion, death	place, and due to the occurred at the time,	cause(s date and) and manner as d place, and due	s stated. e to the cause(s)
	To the within 2 To the comple	Med	29b. Signature and title of certifier	2 and maillier's	wiou.		29c.	License	number		29d. Da	te signed (Mont	th, Day, Year)
	108		+ f a Charle	Som. 1	4		10	00	2.5	674	10	-19-06	
1	Your		30. Name and address of person who	completed cause of	death (Item			121	m	14, So	li.	sbung	, nd. 218 a
ı	Sta Regist	_	31. Date filed (Month, Day, Year)	32. Figist	rar's Signa	ture	rade						

State of Maryland / Department of Health and Mental Hygieng UUb 1 - For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Day **Physician** PM OCTOBER 17, 2006 4:10 GRACE OLIVE BRYAN /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** MONTGOMERY GENERAL HOSPITAL MONTGOMERY OLNEY If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2 N F Yrs. 577-24-7731 Director APRIL 11, 1920 MARYLAND 86 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show ith and Mental Hyglene. 27 Ie marked other then "naturel", or Iteme 23s or 28s-1 shov traumatic event, tra Medical Example and musical 1 ☐ Yes 2 No Director MARYLAND MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Peges 1 and 2 should be filed within 72 hours after deeth v Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "naturel", or Iteme 23a any Injury or other traumatic event, tra Medical Exercises ADDS. 3222 LUDHAM DRIVE 20906 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Marned 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specity: If Yes, Give Year or Dates: Specify: 3 X Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) OWNER 2 FUEL OIL COMPANY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JOHN STROMBERG MARY MILSTED ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) JOYCE BLAND - DAUGHTER 19800 TANBARK WAY, BRINKLOW, MARYLAND 20862 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) FORT LINCOLN CREMATORY 10/23/2006 BRENTWOOD, MARYLAND 21. Signature of Funeral Service HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVENUE, SILVER SPRING, MARYLAND 20906 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or rean failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme lat Cause (Final Physician ASYSTOLE /Medical resulting in death) Due to (or as a consequence of): Examiner CHRONIC RENAL FAILURE 3 YEARS Sequentially list conditions, if any, leading to immediate cause. Entir Underlying Cause (Disease or injury that initialed events Examiner Due to (or as a consequence of): Hospitel or Attending Physician: The law requires that the death certificate be executed use as the burial-transit MALNUTRITION 1 YEAR and resulting in death) Last Due to (or as a consequence of): attending physicien for use as the burial Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4□Pregnant at time of death 5 Other (specify) P.O. 1 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, icate has been sig , page 2 should b 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown CONGESTIVE HEART FAILURE Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 2∐ No 1 ☐ Yes After this certifical funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 🔯 No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 XNatural 5 Pending to Funeral Director: After the funeral Director: After the funeral by the funeral fune 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely (Check only one) within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number BC1082039 OCTOBER 18, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MATTHEW J. CONNOLLY, M.D., 18109 PRINCE PHILIP DRIVE, OLNEY, MARYLAND 20832

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

OCT 2 0

32 Registrar's Signature

2006

35039

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 2:50 P^M October 17, 2006 Anna Delores Brown /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Sunrise of Montgomery Village Montgomery Village Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Nonths Days Hours Min. Sept. 9, 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🔀 F 85 Yrs. 1921 Pennsylvania 181-14-9194 Director Usual Residence of Decedent 10d, Inside City Limits 10b. County 10c. City, Town or Location 10a. State permit. Pages 1 and & structure.
Department of Health and Mental Hygiane.
Importent: if item 27 is marked other than "naturel", or items 23s or 28s-1 structure.
Importent: if item 27 is marked other than "naturel", or items 23s or 28s-1 structure in items 23s or 28s-1 structured in items 23s or 28s or 28s-1 structured in items 23s or 28s or 28s or 28s or 28s or 1 X Yes 2 No Maryland Montgomery Montgomery Village 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20886 United States 19310 Clubhouse Road, #318 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 A No Specify: Specify: White 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Elizabeth Moska1 John Kramrech

Physician /Medical Examiner

19a. Informant's Name/Relationship (Type, Print)

Ronald Lee Brown/ Son

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

the attending physician and 24 hours eftar death.

Funeral Director: After this certificately filled in by the funeral director.

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

20a. Method of Disposition 1 Buriai 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	Chata	rth Lawn C	other place) Octo	ober 20.	nton, Ohi	
21. Signature of Funeral Service License	0		and Address of Facility Park Drive, (DeVol Funer Gaithersburg		
23a. Parti. Eller y el isease, or compilio shock, d'inpat fillure. List only one immediate disease or notion resulting in death)	e cause on each line.	Vascular A		ac or respiratory arrest,		Approximate Interval Between Onset and Death
Sequentially list conditions, b. fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Hemiplegia Due to (or as a conseq Hypertens Due to (or as a conseq	ion				-
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions con	3c. If yes, outcome of pregnant of Live birth 2 Fets 4 Pregnant at time of centre of the birth o	23d. Date of deli Month				
		1. 3		1 Tyes 24a. Was an autopsy performed? 1 Yes 2 23	24b. Were au prior to death?	obabiy 4 Unknown Itopsy findings available completion of cause of
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3		eath (Check only one) Home 5 Residence		Assisted
27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how in		.ny) = 1 v 1 g
1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, fact fy)	ory, office	28f. Location (Street City or Town, Sta	and Number or Ru ate)	iral Route Number,
29a. Certifier 1⊠ Certifying Phys (Check only one) 2 Medical Examin	sicien: To the best of my kneer: On the basis of examination and manner stated.	owledge, death occurration and/or investigati	ed at the time, date and place on, in my opinion, death oc	ce, and due to the cause curred at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
29b. Signature and title of certifier	n.A.		29c. License number	29d. [Date signed (Monti	h. Day, Year)
> quesono	alifon	M	D58069	Oct	tober 18,	2006

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code,

16810 Camberford Street, Derwood, Maryland 20855

DHMH 17 Rev 1/2001

State

Registrar

within 2 To the

Ericson Catipon, M.D., 18550 Office Park Drive, Montgomery Village, MD 20886

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

20

31. Date filed (Month, Day, Year)

32 Registrar's Signature

	•	1 - For Amend #5, perFH	State of Marylan, G864 2/2/07 TT	d / Depa	artment of H	ealth an Death	d Mental Hy	giene Reg. No.	006	35040
Physic	ian	Decedent's Name (First, Middle, Last) T. 1					2. Date of De Month October	Day	Year 2006	3. Time of Death 6:30 a M
/Medi	cal	Julia Bemis 4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of C			inty of Dear	
Exami	ner	10209 Gardiner Av			Silver			Mo	ntgor	nery
Funeral		5. Social Security Number 6. Sex			If Under 1 Year Months Days	If Under 24 Hours	Min (Month Da	h v. Year	9. Bin	thplace (State or Foreign ountry)
Director		130-10-3090	M 2XF	87 Yrs.			Sept. 9	, Year) 1919	Net	w Jersey
and		Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Lo	ocation					10d. Inside City Limits
Maryl -feho	to	Maryland Montgom	nery Si	lver S	Spring					1 AYes 2 No
h the	Irec	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Co	ountry?
th wit	a D	10209 Gardiner Av			20902					States
Baltimore, Maryland 21215-0036 Parit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, if a Mudical Examinar must be notified at any injury or other traumatic event, if a Mudical Examinar must be notified at once.	by Funeral Directo	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1☐ Yes 2☑ No	spanic Origin n, Mexican, F Specify:	n? (Specify Yes or No Puerto Rican, etc.)		Race - Ame Black, Whit ec <i>ify:</i> Wh:	
21215-0036 od within 72 hours afl gjene. er than "naturel", or than Medical Evani		15. Decedent's Educ	cation	16a. Dece	dent's Usual Occupa	ition	f	16b. Kind		
CLZ	ple	(Specify only highest grade	Completed) College (1-4or 5+)	life.	kind of work done of DO NOT use retired))	r working			
ZZ Zgiene gerth	Completed	12		Нот	nemaker				1 Home	2
Maryland nd 2 should be file lith and Mental Hy 27 ie marked oth	Be	17. Father's Name (First, Middle, Last)				1	Name (First, Middle Maheshia		name)	
d Mer marke	၉	John Patron 19a, Informani's Name/Relationship (Ty)	ne Print)	19h Maili	ng Address (Street a	Anna and Number of	or Rural Route Numb		wn. State.	Zip Code)
Man d 2 st th and 17 ien traun	1	Karen Jones / Dau			-		Gaitherst			
Heel tem 2		20a. Method of Disposition	20b. F	Place of Dispo	osition (Name of matory or other place		Date			Town, State
TOT		1 ☐ Burial 2 ☑ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)					0/20/2006	Brent	twood	, Maryland
Baltimore, partit. Pages 1 ar Department of Hee important: If Item any injury or othe once.		21. Signaluje of Funeral Service Conso	9 0	S:	Name and Address Imple Tril	s of Facility oute Fi ille P	uneral and ike; Rocky	l Crema ille,	a ti on Mary	Center Land 20852
		23a. Part1 Enter the disease for complishood, of heart failure. List only or	cations that caused the deat	h. Do not en	ter the mode of dyin	g, such as ca	rdiac or respiratory a	rrest,		Approximate Interval Between Onset and Death
Py60, ate be executed Weddical Examiner hysician and the burial-transit	ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	uence of):	clerosis					
Geath certific death certific e attending pod for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o 9 □ Unknown	aldeath 3	□Ectopic pregnancy □ Other (specify)			23d	. Date of de Month	Blivery Day Year
- E B B	Š	Part II. Other significant conditions con	ntributing to death but not res	sulting in the u	underlying cause giv	en in Part I.		tobacco use Yes 2 □ N		to the cause of death? Probably 4 \textsquare Unknown
Rec he law e has b	Completed	Chronic obstructi	ive pulmonary	disea	se		24a. Was auto perfi 1 Yes		prior to death?	autopsy findings available completion of cause of s 2 \square
of Vital F Physicien: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?				26. Place o	of Death (Check only	оле)		
of Vita Physicien: rithis certific ral director,	2	1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient 2 ☐			4 🗀 14013	sing Home 5 🖾 Res			ecify)
	on	27. Manner of Death 1 ⊠Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor	yat k? Yes 2.∐No	28d. Describe	now injury o	ccurred	
Jivision or Attendate deatler deatler birector: in by the	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h	ome, farm, si fy)			28f. Location	Street and N wn, State)	lumber or F	Rural Route Number,
Hospita 4 hours Funeral	edical C	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my known of the basis of examinating and manner stated.	owledge, dea ation and/or i	th occurred at the tirnvestigation, in my o	ne, date and pinion, death	place, and due to the occurred at the time	cause(s) an date and pla	d manner a ace, and du	as stated. se to the cause(s)
To the within 2 To the complex	₹ S	29b. Signature and title of certifier	^ .		29c. Licens			4		nth, Day, Year)
3		Kynthia M.	Dillion	to DO	HOC	1580.	32	Oct	over	17,2006
		30. Name and address of person who co								
		Cynthia M. Willia	ams D.O. 600	01 Mun	caster Mi	11 Roa	d; Rockvi	lle, l	MD 20	850
S Regis	tate trar	31. Date filed (Month, Day, Year)	32. Abgistrar's Sign	B A	poste					

		For State Registrar	State of Ma		epartme <i>Certifica</i>				gien e () Reg. No.	006	35041	
Physic	cian	Decedent's Name (First, Middle, La	st) Carolyn Vi	rginia Ch	nase			2. Date of De Month	ath Day t 16, 20 0	Year D 6	3. Time of Death 6:56 P M	
/Med Exam		4a. Facility Name (If not institution, given		19			Location of De	ath		unty of Deat		
Funera Directo			Sex 7. Age 1 □ M 2 X 3 F	64 (In yrs. last birti	hday) If Und Months	er 1 Year Days	If Under 24 H	n. (Month, Da	th y, Year) 0, 1942	9. Birtl Co	nplace (State or Foreign untry) Maryland	
Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County MD Ca	lvert	10c. City, Town	or Location		Lusby				10d. Inside City Li <i>m</i> its 1 ☐ Yes 2 🛣 No	
h with the 23a or 28a st be not	al Director	10e. Street and Number 11830 Millbridge Road				ip Code	20657			u.S.	Α.	
ISTYISTIC Z IZ IS-UUSO 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Itams 23a or 28a-f show aumatic avant, the Medical Examinet roust by notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married ★ Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:			edent of H becify Cuba 2 No	ispanic Origin? In, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)	ifly Yes or No- lican, etc.) 14. Race - American In Black, White, etc. Specify: Black			
Z1Z13-UU30 d within 72 hours af giene. er than "natural", or the Medical Exam	Completed by	15. Decedent's E(Specify only highest g. Elementary/Secondary (0-12) 12	ducation rade completed) College (1-4or 5		Decedent's Us (Give kind of v life. DO NOT	vork done use retired	during most of v	working		Someone Else's Home		
id be filed ental Hygi kad other ic avant, I	To Be Co	17. Father's Name (First, Middle, Last) Clarence Stewart							olet Tho	omas		
y, Maryland and 2 should be file ealth and Mental Hy n 27 Is marked oth		19a. Informant's Name/Relationship Mary Ann Butler/daught		1	1830 Mill	ridge R	and Number or load Lusby	Rural Route Numb				
Pages 1 nent of Hanner of		`4 □ Donation 5 □ Other (Specify) Zion Filli Citario Centetery									y, MD	
Balt permit. Departr Imports any inji	- Succe	21. Signature of Funeral Service Lic Slacky 23a. Part 1. Enter the disease, or co	7. Sevel	P	1.	451 Da		Road Prince		k, MD 20	0678 Approximate	
8760, cate be executed BY WE Cate be executed Cate by	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter 'Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. CELLI Due to (or as	o (or as a consequence of): CLULITIS R THIGH o (or as a consequence of): o (or as a consequence of):							Onset and Death from clays Marila	
Box 6 Bath certific attending F for use as	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 TNO 9 Unknown 9 Unkno									olivery Day Year	
'dS, P.O. uires that the dian signed by the detached	þ	Part II. Other significant conditions DM , RENA	s contributing to death I				_		tobacco use		o the cause of death? robably 4 Dunknow	
Vital Records, sician: The law requires t certificate has been signe rector, page 2 should be or	Ω	DIVER	TICULIT	715				24a. Wa aut per 1 🗆 Yes	opsy formed?	24b. Were a prior to death?		
Vital F ysician: Th s certificate director, pag	Be		Hospital: 1 ☐ Inpat	ient 2 NER/O	utpatient 3	DOA Ot		Death (Check onlying Home 5 ☐ Re		□Other (Sp	ecify)	
E ge e	5	27. Manner of _ th 1 _ ural 5 _ Pending 2 _ Accident investiga			Time of Injury M		nyat ork?]Yes 2 □No					
Division To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the tune	Certification:	3 Suicide 6 Could no determin	building, e	njury - At home, f etc. <i>(Specify)</i>				City or T	own, State)		Rural Route Number,	
ha Hospii in 24 hour iha Funari ineletely filli	edical	29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the best taminer: On the basis and manner s	of examination a	ge, death occur nd/or investiga	tion, in my	ime, date and p opinion, death o	place, and due to the occurred at the time	e, date and p	mace, and do	as stated. ue to the cause(s)	
To T To T	Z	5				D.	36960	•	101	17(0	S	
5		30. Name and address of person w SCARIA WATE	accompleted cause of the MD, 32. Regis	death (Item 23a	(Type, Print)	EMA	V RD	LUSBY	MD	, 200	657	
Reg	State jistrar	31. Date filed (Month, Day, Year)	1 7 2006	Bores	H. A	parte	,					

			For State Registrar	State of Maryla	nd / Depa <i>Cei</i>	artment of H	ealth and M Death	lental Hyg	iene 00 (35042
			Decedent's Name (First, Middle, Last,)				2. Date of Deat Month.	h	3. Time of Death
	Physicia /Medic		John :	J. Curry	/			October		06 2:40 pmM
	Examin	_	4a. Facility Name (If not institution, give	,			Location of Death		4c. County of I	ters and
	3.1		5. Social Security Number 6. Se.	-	. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		Birthplace (State or Foreign
	Funeral Director		108-22-5389	M 2□F 75		Months Days	Hours Min.	8/3/193	1 N	Country) New York
0.	pu ,		Usual Residence of Decedent 10a. State 10b. County	100.0	ity, Town or Lo					10d. Inside City Limits
	faryla ed at	ō								1 Yes 2 No
	the h	Director	Md. Howard 10e. Street and Number		Ellicot	10f. Zip Code		1	0g. Citizen of Wha	t Country?
	h with	ID Is	2550 Kensington	Gardens Unit	302	210	043		USA	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel", or Iteme 23e or 28a-f ehow eny injury or other treumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Amarried 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 XYes 2 No. 195 ff Yes, Give Year or Dates: 195	50-	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 🛣 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		American Indian, White, etc. Thite
5-0	72 hc	Completed	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual Occupa kind of work done d	furing most of work	ing	16b. Kind of Busin	ess/Industry
121	within ene then he Me	dmc	Elementary/Secondary (0-12)	College (1-4or 5+) 5+yrs	//re.	DO NOT use retired, Accoutant			Aut	comotive
d 2	illed Hygi other	a l	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, I		
Maryland	uld be Menta wrked write ev	To B	Edward M. Curry					Quinn		
Man	2 sho and I is mu	gi å	19a. Informant's Name/Relationship (T)							te, Zip Code) 21043
e, r	1 and Health In 27 Ther to		Annette Curry/wife			Kensington			302 Ellic 20c. Location - Cit	ott City,Md.
Baltimore,	ages int of h t: If ite		1 🕱 Burial 2 ☐ Cremation 3 ☐ F	Removal from State	cemetery, crer	matory or other place	θ)			sville,Md.
İĦ	artme ortani injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licens		ST Lawi	Name and Addres				mily F.H.Inc.
ä	Depa Impo eny ii		Mohel P. Ch	nato m	0845 41	l12 Old Co	olumbia F	Pike Elli	lcott Cit	y,Md. 21043
	a\$		23a. Part1. Enter the disease, or complishock, or heart failure. List only o	ications that caused the deane cause on each line.						Approximate Interval Between
j .	Physician		fmmediate Cause (Final disease or condition resulting in death)	3eptic	- Sh	och o	due to	line	injection	Onset and Death
	/Medical Examiner			Due to (or as a conse	quence of):					
<i>(</i> **)	₽ ≓	ner	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence of).					
	icate be executed physicien and s the burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	inuance of):					
8760,	sicien buria	alE		4	440/100 51/.					
9	ificate g phys	edical		o.						
.O. Box	The law requires that the death certific Ne has been signed by the attending p bage 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	taf death 3	Ectopic pregnancy Other (specify)			23d. Date o Month	f delivery Day Year
S, P	es that igned b	by PI	Part ff. Other significant conditions co	ntnbuting to death but not re	sulting in the u	nderlying cause give	en in Part I.	23e. Did tol	pacco use contribu	te to the cause of death?
ord	w require been sig should b							1 🗆 Ye	es 2□No 3[Probably 4 DUnknown
Vital Records,		Completed	name					24a. Was a autops perform 1 Yes 2	y prior	e autopsy findings available r to completion of cause of th? Yes 2 No
Vita	Physician: this certific al director,	Be	25. Was case referred to medical examiner?	Hospital:		_ Cthe	26. Place of Deat			
ō		. To	1 ☐ Yes 2 Ø No 27. Manner of Death	28a. Date of fnjury	28b. Time o	f 28c. Injury	at		ence 6 Other (Specify)
ion	Attending I death. ctor: After y the funer	atlor	1 € Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	fnjury	M 1 🗆 Y	(? Yes 2□No			
Division	or Atte ter de: frecto n by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Pface of Injury - At building, etc. (Spec	home, farm, str	eet, factory, office		28f. Location (St City or Town	reet and Number on, State)	or Rural Route Number,
	pital o		29a. Certifier 1 Cartifying Phy	plaining. To the heat of multi-	and death	h	and along	and due to the co	(-)	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical	(Check only 2 Medical Exami	sician: To the best of my kr nar: On the basis of examir and manner stated.	nation and/or in	vestigation, in my op	pinion, death occur	red at the time, d	ate and place, and	due to the cause(s)
	withi To ti	X	29b. Signature and trile of certifier	- 0		29c. License			9d. Date signed (A	,
			Lan	(n)		Doc	5370	C	ctobe,	21,2006
) (12-		30. Name and address of person who co	1430 City	om 23a) (Type, allow	Frint) Fox 1	am ST	EZ	210 8	ouse MD 20715
	Sta Registr		31. Date filed (Month, Day, Year) OCT 23 2	32. A gistrar's Sign	nature					
	riegisti	.		THERE	N. A	carfe				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 35043 State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Vear Month **Physician** 1238 AM Huateng Chen
4a. Fecility Name (If not institution, give street and number) October 17 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 □ M 2 F 23, 66 Oct. 1939 China Director 215-29-7305 Usual Residence of Decedent 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other then "naturel", or items 23s or 28s-1 ehow any Injury or other freumatic event, the Medical Evantinar must be notified at once. 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Directo Maryland Montgomery Gaithersburg 10e. Street and Number 10g. Citizen of What Country? 304 Whitcliff Court 20878 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Asian þ 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Nian Fu Chen Cai Xiang Qu ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Guan Jun Zhou (Husband) 304 Whitcliff Court, Gaithersburg, MD 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 10/22/06 Alexandria, Virginia 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877 21. Signature of Funeral Service Licensee 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheet, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Small Cell Lung Cancer disease or condition Metastatic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, have leaving to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Otra to (or as a consequence of) Examiner Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ettending physicien Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24a. Was an autopsy

Hospital or Attending Physician: The law requires that the death certificate be executed Be Completed 2 Certification: After t death. after death Director: / filled in by

1 Yes 25. Was case referred to medical

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

1		20.1 lace of Dealit [Oreck Only one)										
-	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	☐ ER/Outpatient 3☐ □	OCA Other: 4 Nursing H	Home 5 ☐ Residence 6 ☐ Other (Specify)							
	27. Manner of Death 1 Natural 5 Pending 2 Accident investigate		28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred							
	3 ☐ Suicide 6 ☐ Could not determined		nome, farm, street, facto	ory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)							

29a Contilior Certifying Physician: To the best of my knowledge, death consider at the time, date and place, and due to the naise(s) and manner as stated Certifying Physician: To the best of my knowledge, death annual at the time, date and place and due to the cause(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Paul Barren MD MD0060335 October 17, 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Philip Drive #327 Prince Olney, MD 20832 Paul Bannen M.D 18111 32 Registrar's Signature 31. Date filed (Month, Day, Year) 2006 OCT 2 0

State Registrar

Medical

DHMH 17 Rev 1/2001

To the Hospital within 24 hours a To the Funerel D

State of Maryland / Department of Health and Mental Hygiene 2 0 0 6 35044 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** October 16, 2006 11:12 a M Sharon Ann Campbell /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Montgomery Rockville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 9, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Min. Hours Months Days 1 □ M 2 Q F 087-32-3126 65 1941 New York Director Usual Residence of Decedent within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b County r then "naturel", or Items 23e or 28e-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 TNo Director Maryland Montgomery Damascus 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9813 Bethesda Church Road Apt. 204 20872 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ဩ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Timore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of 8usiness/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "ns eny injury or other treumatic event, the Medic once. Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Denta1 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helene Marianne O'Neill John Frederick Kelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tom Kelly/Brother 6226 Capella Avenue, Burke, VA 22015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State October 20, 1 ☐ Burial 2XXX remation 3 ☐ Removal from State Fort Lincoln Crematory 2006 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fluneral Service Licenspe 22. Name and Address of Facility Simple Tribute, 1040 Rockville Pike, Rockville, Eugym 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a Glioblastoma Multiforme /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to for as a consequence of) Examiner certificate be executed tran and Due to (or as a consequence of) the ettending physicien a hed for use as the burial-P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) ☐Yes 2√XNo detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 90 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Machine Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 Yes ¾XNo Division of Vital iel or Attending Physicien: s atter death.
I Director: After this certifice of in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo ဥ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural M 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Mospitel pelli Funerel 12 Certifying Physician: To the best of my knowledge death occurred at the time date and place and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 ho To the Fune completely fi Medical (Check only one) t t 29d. Date signed (Month, Day, Year) 29b. Signatur 29c. License number ů D35635 October 16, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Kaplan, MD 18111 Prince Phillip Drive, Rockville, MD 20832 31. Date filed (Month, Day, Year) State 5006 20 Registrar

			State of Maryland / Departm	ent of Health and M	•	ne On o c	2501.5			
			1 - State Registrar 1. Decedent's Name (First, Middle, Last)	ate of Death	Reg.	2006	35045			
	Physicia	an	Marie Thomas Corley		Month	17, 2006	3. Time of Death 6:15 P M			
	/Medic Examin			City, Town, or Location of Death	OCCODE	4c. County of Death	1 0 1 2 0			
			Civista Medical Center	La Plata	Charles					
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 X F 89 7. Age (In yrs. last birthday) If Ut Mont	ths Days Hours Min.	8. Date of Birth (Month, Day, Ye Oct. 2, 1	(Month, Day, Year) Country)				
	and wo	}	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		,		10d. Inside City Limits			
	Mary a-f ehc	tor	Maryland Charles Waldorf				1 ☐ Yes 2 🎇 No			
	or 284	Funeral Director		. Zip Code	10g.	Citizen of What Cor	untry?			
	seth w	erai	70 Village Street, Apt. 304 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was D.	20602	acity Yes or No-	USA 14. Race - Amer	ncan Indian.			
36	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 le marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	by Fun	1 Never Married 2 Married 1 ∏Yes 2 X No	ecedent of Hispanic Origin? (Spe specify Cuban, Mexican, Puerto os 2X No Specify:	Rican, etc.)	Black, White Specify:				
9	2 hours	ted t	15. Decedent's Education 16a. Decedent's	Usual Occupation f work done during most of worki	160	o. Kind of Business/l	ndustry			
21	han "n	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	T use retired)	ng	D t	- t Ct			
d 2	filed v Hygie other ti		12 Bookkee	•	e (First, Middle, Mai	Departme	nt Store			
/lan	uld be Mental rrked c	To Be	John Granville Thomas	Marie Go	oldfinch	Barker				
Maryland 21215-0036	12 sho h and 7 le mu traum		1111	ress (Street and Number or Rura			ip Code)			
re,	Healt Healt tem 2		20a. Method of Disposition 20b. Place of Disposition	fer Rd., Falls (A ZZU4Z c. Location - City or T	Town, State			
E S	Pages nent of ant: if ary or		IA IBurial 2) ICremation 3 IHemoval from State	dens Cem. 10-22	2-06 Ar	lington,	VA			
Baltimore,	permit. Departn Imports any inju		11100000	e and Address of Facility		Washingt				
	40544		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.			Waldorf,	MD 20604 Approximate			
	Physician			EUMONIK	,		Interval Between Onset and Death			
	/Medical Examiner		resulting in death) a. Due to (or as a consequence of):	2 4 717 0 1 1 7 7 7			1 WCC Z			
	Lxammer	-a	Sequentially list conditions, b. Due to (or as a consequence of).							
	cuted nd ransit	Examiner	it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.							
760,	icate be executed physicien and s the burial-transit		resulting in death) Last Due to (or as a consequence of):							
687	ficate I physi	edical	d							
Вох	leath certificat attending phy I for use as the	M/us	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectop	ic pregnancy		23d. Date of deli				
P.O. E	The law requires that the death certilica sie has been signed by the attending ph bage 2 should be deteched for use as th	Physician/Med		r (specify)		Month	Day Year			
	res that igned b be dete	by Pt	Part II. Other significant conditions contributing to death but not resulting in the underlying	ng cause given in Part I.	23e. Did tobac	co use contribute lo	the cause of death?			
ord	v requir been si should I				1 Tyes	2 No 3 Pro	obably 4 Unknown			
Vital Records,	The law sete has b page 2 s	Completed			24a. Was an autopsy performed	prior to death?	topsy findings available completion of cause of			
ita		BeC	25. Was case referred to medical	26. Place of Death	1 Yes 2 Check only one	No 1 ☐ Yes	2.240			
	\$.∞ ₽	မ				e 6 Other (Spec	cify)			
Ou	Attending I ir death. ector: After by the funer	tion	27. Manner of Death 1 SNatural 5 □ Pending 2 □ Accident investigation 28a. Date of Injury (Month, Day Year) Injury M	28c. Injury at Work?	28d. Describe how	injury occurred				
Division of	il or Attend after death I Director: / d in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	ctory, office	28f. Location (Stree City or Town, S	t and Number or Ru State)	ral Route Number,			
_	Hospits 4 hours Funarel ely fille	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occu 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	rred at the time, date and place, ation, in my opinion, death occurr	and due to the caus ed at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)			
	To the within 2 To the complet	-	4113 1141101 514153	29c. License number	29d.	Date signed (Month	n, Day, Year)			
)			Sesen	228281		OCTOBE	R19,2006			
· (NB 12		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WELLOW BEWELL 9 1 31 (IS 31. Date filled (Month, Day, Year) OCT 2 0 2006 32. Registrar's Signature	CATAWAY ED,	CLINID	w, mo	20735			
	Sta Registr	ite ar	31. Date filed (Month, Day, Year) OCT 2 0 2006 32. Rigistrar's Signature	E .						

Please Type or Print in Black Indelible Ink
of Maryland / Department of Health and Mental Hydiene

20	106	35	04	-
----	-----	----	----	---

rman Campi	Jen	State of Maryland / Department of F		yglene Reg	2001	3504
*Pffysic		Decedent's Name (First, Middle,Last)		2. Date of Death Month C October 20,		3 Time of Death 1116 hrs
edical Exam	iine	Herman Campberr	City, Town, or Location of Death	October 20,	4c. County of Death	11101113
			Cheverly		Prince George	
Funera Director			f Under 1 Year If Under 24Hrs Months Days Hours Min.	7	(MM/DD/YYYY) 9 Birt Foreig	1
Director		577-88-2048 1 X M 2 F 45 Yrs.		12/02/	1960	Wash. DC
v any		10a State 10b County 10c. City, Town or Location				10d Inside City Limits
yland -f shov once,	ţ	DC 10e Street and Number	Washingto		Citizen of What Cour	1 X Yes 2 No
vith the Maryland s 23a or 28a-f show a	Director	602 - 46th St., SE #33	20019	100	United	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other tranuntic event, the Medical Examiner must be notified at once.	era		ecedent of Hispanic Origin? (Sp specify Cuban, Mexican, Puerto		14. Race - Americ	
er death , or ite	Funeral	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes	es 2 X No specify:	rtiouri, cto.,		31ack
ours after a	<u> </u>	or Dates.	Usual Occupation (Give kind of v		16b. Kind of Business/I	
16 n 72 hc tan "na ical Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12th	of working life. DO NOT use reti	red)	n	
d withing yeare the Med	l c	17 Father's Name (First, Middle, Last)	Handyman 18.Mother's Name	(First, Middle, Ma	Privaiden Surname)	ate
1215 d be file ental H arked o	Be	George Campbell		Nancy		
ID 2 Shoulk and M 27 is m	2		ddress (Street and Number or R			
Land Health		20a Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition crematory or other	n (Name of cemetery,		20c Location - City or	
imo Pages nent of iant: I		4 Donation 5 Other Specify: A Harmony Me	morial Park 11,			
Balt permit Departu Importu	,		e and Address of Facility St 4001 Benning Ro		uneral Home	
Physician	1	23a. Part I Enter the disease, or complications that faused the death. Do not enter the failure. List only one cause on each line	mode of dying, such as cardiac of	r respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
/Medica Examine		Immediate Cause (Final disease a. <u>Hypertensive cardiovascul</u>	ar disease			Death
		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.				
	ingr	if any, leading to immediate Due to (or as a consequence of):				
ą d	Evaminer	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
60, ate be executed by sician and busician and	100		0 10/7/04 TT			
60, cate be	Modical	#23a,27,perME, g86	2, 12///06 TT		23d Date of delivery	,
Box 687 death certific the attending p	/ucio	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal 4 Pregnant at time of death 5 Other	death 3 Ectopic pregnation (Specify)	ancy	Month E	oay Year
nof Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be executed. After this certificate has been signed by the attending physician and manal discords mana? A should be detached for use as the furial - transit	Dhyeirian	1 Yes 2 No 9 Unknown 9 Unknown		Logo Diduck		the serves of death?
P.O.	4		eriying cause given in Part I.		2 No 3 Prob	
rds, require been si	Completed			24a. Was ar		topsy findings available
Reco	S S S			perform	ned? death?	
tal Ferina Certific	0	25. Was case referred to medical examiner?	26.Place of Death (Check			
of Vi ling Physi After this	F	1 V Yes 2 No Impatient 2 Envoupagement			Residence 6 Other	:
	1	1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation	1 Yes 2 No			
Division of Vital Records, Hospital or Attending Physician: The law requir 24 hours after death Funeral Director. After this certificate has been si	Contistionation.	3 Suicide 6 Could not be determined (Specify)	factory, office building, etc.	28f. Location (St or Town, Sta	treet and Number or Ruate)	ral Route Number, City
Lospita 4 hours Funera			d at the time, date and place, and	d due to the cause	(s) and manner as star	ted
Division To the Hospital or Attent within 24 hours after death To the Funeral Director	Modioa	one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated				
->-	1	29b. Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed (Mo. October 21, 2006	
		30, Name and address of person who completed cause of death (Item 23a)	3.5.M.E.		20,000, 21, 2000	-
R		Pamela E. Southall, MD Assistant Medical Examiner 111	Penn Street, Baltimore, I	MD 21201		
1	Stat	ar Date filed (Month, Day, Year) 32. Registrar's Signature Series S. Species				

ORIGINAL

			1 - State of State of Registrar	Maryland / Depa	rtment of Hea			ne No 200	6 35047
			Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
	Physicia		Richard Joseph I	DeSantis			October	23, 200	
	/Medic Examin		4a. Facility Name (If not institution, give street and number		4b. City, Town, or Loc	cation of Death	000000	4c. County of D	
	LAGITIII	-	7542 I Street		Chesapeake	Beach		Cal	vert
	Funeral		5. Social Security Number 6. Sex 7	Age (In yrs. last birthday)	If Under 1 Year If	Under 24 Hrs.	8. Date of Birth	9.	Birthplace (State or Foreign
	Director		579-78-5481 ¹ X № 2□ F	51 Yrs.	Months Days H	Hours Min.	(Month, Day, You Dec. 7.	1954 Ma	aryland
	D		Usual Residence of Decedent						-
	how	_	10a. State 10b. County	10c. City, Town or Lo					10d. Inside City Limits
	B Ma	cto	MD Calvert	Chesa	peake Beac	ch			1X Yes 2 ☐ No
	or 28	oj.	10e. Street and Number		10f. Zip Code		10g	. Citizen of What	
	death with the Maryland ms 23a or 28e-f show r.must be notified at	Funeral Director	7542 I Street		207			U.S.	
	r dex	une	Armed Ford	ent Ever in U.S. 13. \ es? 1	Vas Decedent of Hispa f Yes, specify Cuban, N	anic Origin? (Spe Mexican, Puerto I	cify Yes or No- Rican, etc.)		vmerican Indian, Vhite, etc.
9	or I	by F	1 ☐ Never Married 2 Married 1 ☐ Yes 2 If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Date		☐ Yes 2X No S	Specify:		Specify:	white
2-003p	hour	De la	15. Decedent's Education	es: 1975–78	lent's Usual Occupation	n	16	b. Kind of Busine	ass/Industry
ဂ်	n 72 n na n na	Completed	(Specify only highest grade completed)	(Give	kind of work done durir	ng most of working	ng	b. Kind of Dusine	ssa muusti y
717	within energy that the	mc	Elementary/Secondary (0-12) College (1-4	lor 5+)	ical engin			S. Gove	rnment
0	Hyg Hyg	Ö	17. Father's Name (First, Middle, Last)				(First, Middle, Ma.	iden Sumame)	
yland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene if Health and Mental Hygiene item 27 is marked other than "natural", or Items 23a or 28e-1 show other traumatic avent, the Modical Examiner must be notified at	To Be	unobtainable			Doro	thy S	Strickla	nd
<u>ک</u>	shound M	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street and	Number or Rura	l Route Number, C	ity or Town, Stat	e, Zip Code)
Z	nd 2 alth a 27 is		Nancy DeSantis, wife	7542	? I St.,	Chesape	ake Beach	n, MD 2	0732
ē,	permit. Pages 1 and 2 Depertment of Health s Important: If item 27 is any injury or other tra once.		20a. Method of Disposition	20b. Place of Dispo	sition (Name of natory or other place)	D	ate 20	c. Location - City	or Town, State
Ē	Page Tent of Try or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State of the following state of the stat	Metropolit	an Cremato	ory 10/2	6/2006 1	Alexandr	ia, VA
Baitimor	mit. Pertra porta y inju	١,	21 Signature of Funeral Service Licens	22	. Name and Address of	of Facility Rau	sch Funer	cal Home	, P.A.
ñ	Depermine Depermine Supermine Superm		Rugal Acilo	ach 83	325 Mt. Har	mony La	ne, Owing	gs, MD	20736
			23a. Part1. Enter the disease, or complications that cal	used the death. Do not ent	er the mode of dying, s	such as cardiac o	r respiratory arrest	,	Approximate Interval Between
	Physician		tmmediate Cause (Final	eukomi	1				Onset and Death
	/Medical		disease or condition resulting in death) a Due to (o	r as a consequence of):					70013
	Examiner		a second reason by						
H	_ ~	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	r as a nonsequence of):					TEI .
	ate be executed hysicien end the burial-transit	Examiner	that initiated events c.						
Ď,	e exe	Ä	resulting in death) Last Due to (o	r as a consequence of):					
0/g	ate bi	Icai	d						1
٥	death certificate e ettending phys d for use as the	Physician/Med	IF FEMALE:					1	
X Q Q	ath ce ttendi	an/	23b Was decedent pregnant 23c. If yes, outcome	ome of pregnancy th 2 Detail death 3 D	Ectopic pregnancy			23d. Date of Month	delivery Day Year
	the eff	Sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown		Other (specify)			leionin	Day 1 out
7. O	d by the	Ph		th hut not condition in the	deskies en en en en en	- Death	220 Did tobar	an usa cantribut	e to the cause of death?
Ś	w requires thet the de been signed by the should be detached	þ	Part II. Other significant conditions contributing to dea	un but not resulting in the ui	idenying cause given in	n Parti.	1 ☐ Yes	1	Probably 4 Unknown
ora G	requi	ted					: : : : : : : : : : : : : : : : : : : :		
ပ္	G & C	Completed					24a. Was an autopsy	24b. Were prior	autopsy findings available to completion of cause of
<u>≖</u>	page Th	င်					performe 1 ☐ Yes 2	d2 deat	
VII	sician: Th certificate irector, pag	Be	25. Was case referred to medical examiner?				(Check only one)		
0		2	1 162 5 10 1 1 1 In	patient 2 ER/Outpatien	t 3 DOA Citer	4 Nursing Hor	ne 5 Residenc		Specify)
	Iter Ter	lon	27. Manner of Death 1 Natural 5 □ Pending 28a. Date of (Month)	Injury 28b. Time of Injury	Work?		28d. Describe how	injury occurred	
DIVISION	Attending r death. sctor: Alter by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	of Injury - At home, farm, str		2 □No	194 Location (Street	at and Number o	r Rural Route Number,
<u>≥</u>	or A after Dirsc in by	ertification:	4 Homicide determined 286. Place of building	g, etc. (Specify)	eet, factory, office	-	City or Town,		ridizi riobte Natibet,
_	To the Hospital or Atlandi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	O	29a. Certifier 12 Certifying Physician: To the t	nest of my knowledge death	occurred at the time	date and place is	and due to the carr	se(s) and manns	r as stated
	24 h	edicai	(Check only 2 Medical Examinar: On the barone)	sis of examination and/or in	restigation, in my opinio	on, death occurre	ed at the time, date	and place, and	due to the cause(s)
	omply	Me	29b. Signature and title of certifier		29c. License nu	umber	29d	. Date signed (M	lonth, Day, Year)
	-> F 0		> hatallate	I	DOTIS	9061	0	tober	23,2006
•			30. Name and address of person who completed cause	of death (Item 23a) (Tyne	Print)	1 - 4 1		7100	- /
	10+1		110 Hospital Road.	Dute 21	2 Prin	ue for	edenick	_ MD	20678
	Sta	ite	31. Date filed (Month, Day, Year) OCT 2 3 2006	gistrar's Signature	1 4. 77	-			
	Regist		OCT 2 3 2006 Page >	10					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician EULA DALTON , 2006 7:45 AM Ortober /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Nursing Harford Citizens Home Houve de Crace If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 M 78 229-32-455 Director Virginia 07/15/1928 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show f Health and Mental Hygiene. Item 27 Is marked other then "neture!", or Iteme 23a or 28e-f show other traumatic event, the Medical Examinar must be notified at MD Harford Aberdeen **Funeral Director** 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 2400 Old Post Road 21001 Lot 8 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Vermit. Pages 1 and 2 should be filed within 72 hours after to D. kartment of Health and Mental Hygiene. Importent: If Item 27 is marked other than "naturel", or item eny injury or other traumatic event, the Modical Examinations. 1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify Be Completed by 3 XWidowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ Emmett Smith Nora Spencer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Ann Cather (Daughter) 2400 Old Post Rd. Lot-8, Aberdeen, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/1/06 Aberdeen, Maryland Harford Mem. Gdns. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 rart1. Enter the disease, or condications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Due to (or as a ponsequence of): /Medical Examiner sclesi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Be Completed by Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-transi Due to (or as a consequence of): resulting in death) Last Records, P.O. Box 68760. 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4☐ Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 DUaknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 1 NO 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Medical Certification: To 2 EP/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation after death.

Director: Af
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 120215 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FARMA. S avenue Warreck greek NO21078 M. D Union 661 31. Date filed (Month, Day, Year) 37. Registrar's Signature 03 2006

DHMH 17 Rev 1/2001

Registrar

			State of Maryland / Department of Health and M		9							
			1 - State Registrar Certificate of Death		No2006	35049						
			Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year	3. Time of Death						
	Physici /Medio		OLIVER JOSEPH DEMARET, JR.	OCT.22,	2006	7:25PM ^M						
	Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death							
			CHARLOTTE HALL VETERAN'S HOME CHARLOTTE HAL 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year I If Under 24 Hrs.		CHAR							
	Funeral Director		5. Social Security Number 195-16-0777 Usual Residence of Decedent 6. Sex 17. Age (In yrs. last birthday) Yrs. 195-16-0777 Nonths Days Hours Min.	8. Date of Birth (Month, Day, Y DEC . 8 , 1	924 ST.	place (State or Foreign http:// MARY S						
	ehow		10a. State 10b. County 10c. City, Town or Location		1	0d. Inside City Limits						
	-fet	cto	MARYLAND CHARLES LA PLATA			1XYes 2□No						
	or 28	Oire	10e. Street and Number 10f. Zip Code	100	. Citizen of What Cour	ntry?						
	ath w	rai	101 WESLEY DRIVE, APT. 109 20646		U.S.A.							
36	s 1 and 2 should be filed within 72 hours after death with the Maryland I Heelth and Mental Hygiene. I then 12 is marked other than "natural", or items 23s or 28s-f show other treumstic event. Its Medical Examinations is notified at	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I I Yes, Give I 9 4 3 - 1 9 4 61 Yes X No Specify:	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: WH	etc.						
21215-0036	hours tural	ed b	3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation	16	b. Kind of Business/Inc							
5	n "na	Completed	(Specify only highest grade completed) (Give kind of work done during most of workii	ng le	b. King of business/in	dustry						
212	filed with Hygiene ther the	EO	Elementary/Secondary (0-12) College (1-4or 5+) 12 ARCHTTECTURAL DRAFTS	MAN WA	T.LACE CO	NSTRUCTION						
	al Hygid I other vent,	Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name			WOINGCIIO.						
Maryland	should be and Mental marked o	2	OLIVER JOSEPH DEMARET, SR. ELIZABET	H MARY	MINNO							
lar	2 sho		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura									
	1 and Heelth Pm 27 Iher t		MARGIE R. DEMARET-WIFE 101 WESLEY DRIVE AP 20a. Method of Disposition (Name of Disposition (A PLATA							
و			1 ☐ Burial 2 MCremation 3 ☐ Removal from State cemetery, crematory or other place)	1								
Baltimore,			4 Donation 5 Other (Specify) METROPOLITIAN CREMATORY 10 – 21. Signature of Fyneral Service Licensee M0047 9 22. Name and Address of Facility	29-06 A	LEXANDRI.	A, VA						
Ba	permit. Depertm Imports any inju		RAYMOND FUNERAL			3						
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of	ND 2064 r respiratory arres	6	Approximate						
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final			Interval Between Onset and Death						
1	/Medical		disease or condition resulting in death) a. Cono cum andry durant Due to (or as a consequence of):									
н	Examiner		Immediate Cause (Final disease or condition resulting in death) a. Corror own antlery durant Due to (or as a consequence of): Sequentially list conditions. b. Sever ferepheral vascule	ar due	ene							
	pe ji	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury									
de	be executed sicien and burial-transit	хап	resulting in death) Last Due to (or as a consequence of):									
760,	te be executed ysicien and le burial-transit	caiE										
687	a × a		d.									
Вох	leath certificat ettending phy i for use as the	N/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delive	iry						
	death	Physician/Med	in the past 12 months? 1		Month	Day Year						
P.O.	et the de d by the stached	Phys	9 Unknown									
Vital Records,	The law requires thet the death certifica ate has been signed by the ettending ph page 2 should be detached for use as th	۾	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		cco use contribute to th	1/						
Ö	w require been sli should t	Completed										
Re	The fav	E		24a. Was an autopsy performe	d? death?	psy findings available inpletion of cause of						
<u>a</u>	ician: Th certificate rector, pag	ပိ										
Ξ		0.0	examiner? Hospital: 1 Innatient 2 FB/Outpatient 3 DOA Other: 4 Hospital: 1 Innatient 3 DOA Other: 4 Hospital: 1 DOA Other: 4									
u of	ng Phys ter this neral di	T :u	A STATE OF THE STA									
Si	endir eath. or; Af	atic	2 Accident investigation M 1 Yes 2 No									
Division	Hospital or Attending 24 hours efter death. Funeral Director; After tely filled in by the fune	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town, S	et and Number or Rura State)	I Route Number,						
ш	pital		29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a									
	To the Hospital or Attending within 24 hours effer death. To the Funeral Director; Attercompletely filled in by the funer	Medical	29a. Certifier (Check only one) 29a (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a construction of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the caused at the time, date	se(s) and manner as st and place, and due to	ated. the cause(s)						
	To the within 2 To the complet	Me	29b. Signature and title of certifier 29c. License number		. Date signed (Month,	-						
			AMMOW MD 20060120 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. Waei Hagethma 100 (Hospital Rd Prince Fresh	10	0/23/06							
	(X)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)									
	.,C.		A. Waei Hagethma 100 Hospital Rd Prince Fresh 31. Date filed (Month, Day, Year) NUV 0 2 2006 32. Registrar's Signature	enck, r	D 2067	8						
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature									
	negisti	ar	January 20 Marian									

State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar 06 Certificate of Death Reg. No. 1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 21:45 M JANICE ELAINE **EVANS** OCTOBER 24 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ALLEGANY MEMORIAL HOSPITAL CUMBERLAND If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year **Funeral** 1 □ M 2 🗓 F 54 Director SEPT.19,1952 PENNSYLVANIA 182-46-5558 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature!" ---" any njury or other traumatic aver. 10c. City Town or Location 10d Inside City Limits 10a State 10b. County 1 ☐ Yes 2 No Director FROSTBURG ALLEGANY MD 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 16810 MONTEL ROAD, S.W. 21532 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ▼ No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2 SURGICAL TECHNICIAN HOSPITAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BECKER SIPE **GERALDINE** J. ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16810 MONTEL RD., S.W., FROSTBURG, MD DALE EVANS / HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Altoona Area Crematory Oct 31 06 Altoona, PA 22 Name and Address of Facility SERVICE, P.A. 21. Signature of Funeral Service Licensee 1302 NATIONAL HIGHWAY, LAVALE, MD 21502 23a. Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 1 DAY a. SEPSIS /Medical Due to (or as a consequence of): Examiner YEARS b. EMPHYSEMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit death certificate be executed Due to (or as a consequence of): ettending physicien for use as the burial Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) ed by the e 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ MULTIPLE SCLEROSIS, DIABETES MELLITUS, HYPERTENSION 1 Yes 2 □ No 3 □ Probably 4 □Unknown Completed peen 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No page 2 s 2/2 No certificete 1 Yes 2.2 No Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 2 ER/Outpatient 1 Inpatient ٩ 3 DOA 28a. Date of Injury (Month, Day Year) After the funeral 28c. Injury at Work? Manger of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 2 Accident 5 Pending М 1 ☐ Yes 2 ☐ No investigation Director: / 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as serious.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical ۽ ÷ 29b. Signature and title of cedified 29c. License numbe 29d. Date signed (Month, Day, Year) ٥ $\mu_{\mathcal{O}}$ OCTOBER 25, 2006 D46346 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 625 KENT AVE., JOHNSON HEIGHTS MED. BLDG., CUMBERLAND, MD DR. HUMA SHAKIL, 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

NOV 0

3 2006

3000

			1 = State Registrar amend #19a	State of Ma Per Inf	arylan G861	d/Depa 11/13	rtmei 106 tilica	nt of He	ealth a Death	and M	ental Hy	gier	200	6	350)51	
	- 7	•	Decedent's Name (First, Middle, Last)							1	2. Date of De		10.		3. Time of		
	Physici		Katherine Mae Eyle	er							Octobe	er	16, 20	^{(ear} 06	8:57	Ам	
	/Medio		4a. Facility Name (If not institution, give s				4b. City	, Town, or	Location o	f Death		_	4c. County of				
		6 . i	Brinton Woods Nursi	ing & Reh	ab. (Center	Svl	cesvi	11e				Carro1	1			
-	Funeral	P\$1	5. Social Security Number 6. Sex	7. Ag		last birthday)		If Under 1 Year If Under 24 Hrs. 8. Date of Months Days Hours Min. (Month					irth 9. Birthplace (State of Country)				
	Director		214-18-3001	M 200 F	87	Yrs.	NOTICES	Days	riours	IVIII.	10/10/	191	9		land		
	pu.		Usual Residence of Decedent 10a, State 10b, County		10c Cit	y, Town or Lo	nation						10d. Inside City Limits				
	sho	'n				•	cation									2 No	
	28a-f	ect	Florida Brevard 10e. Street and Number		U.	ocoa	104.7	p Code				100.0	Citizen of Wh	at Cour			
	a or	ក់		1			329					US.		iai Coun	itr y :		
	eath	Funeral Director	1430 Dixon Bouleva	12. Was Decedent I	Ever in U	S 13 V	1		snanic Oric	nin? (Sne	cify Yes or No		14. Race -	Americ	an Indian		
	ther d	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2XX			f Yes, spe	cify Cubar	n, Mexican	, Puerto I	Rican, etc.)	,	Black,	White,	etc.		
920	urs at	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1 🗆 Yes	2XNo	Specify:				Specify:	Whit	:e		
21215-0036	2 hou	ted	15. Decedent's Educ			16a. Deced						16b.	Kind of Busi				
212	hin 7	pje	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5	+)	life. l	DO NOT	ork done di use retired)	u <i>ring m</i> ost)	or workii	ng						
7	gien gien	Completed	12			Clerk						Te	lephon	e Co	mpany		
p	be filed within 72 hours after death with the Maryland ital Hyglene. d other than "natural", or items 23e or 28e-f show event, the Medical Exeminal must be notified at	Be (17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle	, Maid	en Sumame)				
yla	Ment Ment prke prke	2	William Eyler						Ida	P. M	iller						
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Importent: If Item 27 is marked other than "natural; or Items 23s or 28s-f show any figury or other traumatic event, the Madical Examinational be nullified at ance.		19a. Informant's Name/Relationship Tyr				•				l Route Numb						
	l and lealth im 27	30	Susan Kolb/ Daught 20a. Method of Disposition	er	20h B	4014			I Koa		ings M:						
O	iges if le		1 ☐ Burial 2 🛣 Cremation 3 ☐ Re	emoval from State	c	emetery, cren	natory or	other place					Location · C		WII, State		
Baltimore,	rt. Parturent		4 Donation 5 Other (Specify)		Hu	ntt Cr		-			/2006	_	ldorf,		1 **		
Ba	Dermi Depa Impo any it		21. Signature of Emeral Service License								ert E.				al Hom	e	
2,0			23a. Part1. Enter the disease or complic	cations that caused	the deat				•		d Bowie		.ub 207	1)	Approximat	te	
	7 (T) &		23a. Part1. Enter the disease or complic shock, or heart failure. List only on Immediate Cause (Final												Interval Bet	twe <i>e</i> n Death	
	Physician /Medical		disease or condition resulting in death)	Chronic			ve Pu	ıLmona	ary D	isea	se			- /	Year	S	
	Examiner		1	Due to (or as Primary			ive I)emeni	tia					-	⁷ Year	S	
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as											ıcuı		
	cuted Id ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events														
ó	en ar en ar irial-t	Ä	resulting in death) Last	Due to (or as	a conseq	uence of):											
8760,	cate be executed physicien and the burial-transit	dicai	€ d														
9	ertifica ing pl	Med	IF FEMALE:														
Вох	ath ce ttend or us	an/	23b. Was decedent pregnant	3c. If yes, outcome 1☐Live birth	2 Feta	Ideath 3□		regnancy					23d. Date Month		*	Year	
0	law requires that the death certific as been signed by the attending p 2 should be detached for use as	Physician/Me	in the past 12 months? 1 □ Yes 2 2 1 No 9 □ Unknown	4□Pregnant at 9□Unknown	time of d	eath 5□	Other (s	pecify)					WOIT	•	Day	Toal	
<u>.</u>	hat the		Part II. Other significant conditions con	tributing to death b	it not resi	ulting in the ur	nderlying	Carres Gires	n in Part I		23e Did t	ohaco	o use contrib	ute to th	e cause of o	teath?	
Vital Records,	signe d be	1 by		g to doubt of	211101100	annig in this as	noonying	54455 g. 16	ir iii i Qirti,						ably 4 ⊟t		
Ö	v requir	ete											-				
Rec	0 C 0	Completed									24a. Was auto		pric	ore autor or to cor ath?	osy findings apletion of c	available ause of	
a			or Was and offered to a start				10-10-10				1 Tyes	2 24	4o 1 E	Yes	2□ No		
		o Be	25. Was case referred to medical examiner?	ospital:		5B/0 · · ·		Othe			Check only						
ō		-1	1 Yes 2XXNo	1 🗌 Inpatie 28a. Date of Injur		ER/Outpatien 28b. Time of		UA	42 <u>X</u> Nul		ne 5 Resi				')		
on	ding Ph th. After th funeral	tior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da)	Year)	Injury	м	28c. Injury Work 1 ☐ Y	? 'es 2 □ h				,,				
Division	after death. after death. Director: After d in by the fune	fica	3 Suicide 6 Could not be	28e. Place of Inju			eet, facto				28f. Location (or Rura	l Route Num	iber,	
á	al or A s after I Direct d in by	Certification:	4 Homicide	building, etc	c. (Specify	y)					City or To	wn, Sta	1 <i>te)</i>				
	To the Hospital or At within 24 hours after d To the Funeral Direct or mpletely filled in by		29a. Certifier 1. Certifying Phys	ician: To the best of	of my kno	wledge, death	occurred	at the time	e, date and	d place, a	and due to the	cause	(s) and manr	ner as st	ated.		
	o the Ho ithin 24 o the Fu mpletel	edicai	(Check only 2 Medical Examin	and manner sta	examina ited.	uon and/or inv	vestigatio	n, in my op	inion, deat	n occurre	at the time,					-)	
	To the within 2 To the complet	Σ	29b. Signature and title of certifier				- 1	c. License					Date signed (Day, Year)		
			+ Calruh A.	/weer	Du	12		0201	RD			/(0/18/0	k			
			30. Name and address of person who con	mpleted cause of de	eath (Item	1 23a) (Type,	Print)	0	22	<u></u>	. 20 21 20	1.7	200	1;		ľ	
	6		31. Date filed (Month, Day, Year)	5, 190	rio Ciere	000 61	DCE	y XC	$m\nu$	ELVE	PSBU PC	MI	1 6 1730	/			
	Sta Registr		OCT 1 9 200	32 Registra	a s signa	k L											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #28a, perME, g863 1/17/07 TT
State of Maryland / Department of Health and Mental Hygiene 1- For State of Maryland / Department of Fleath a 1- Registrer Amen ditem#28f, perME,G861,11/15/06 Dertificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** , Esworthy 22:54 Kelsie 12 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Mary land | Sulfimere | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number Medical Center 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ XF 214-23-0717 18 3, 1988 Yrs. January Director Maryland Usual Residence of Decedent the Manyland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "naturel", or Items 23s or 28s-f ehow the Medical Examinar must be notified at 1√2 Yes 2 No Frederick Director Maryland Frederick 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 306 Heather Ridge Drive 21702 Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black, White, etc. 72 hours after 1 □ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Depertment of Health and Mental Hygiene. Important: if Item 27 ts marked other than "nat eny injury or other treumstic event, the Madica once. Elementary/Secondary (0-12) College (1-4or 5+) Clothing 12 Salesclerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kirk Esworthy Diana Shrout ္က 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Diana Shrout - Mother 306 Heather Ridge Drive, Frederick, Maryland 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Olivet Cemetery 10-20-2006 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal e of Funeral Service censee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21702 Mulle MI 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** omplications drowning neur /Medical Due to (or as a consequence of): Examiner Brain Anoxic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit MEDICAL EXAUTHER or Attending Physician: The law requires that the death certificate be executed AROS Due to (or as a consequence of) attending physicien for use es the buria Box 68760. Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) 4□Pregnant at time of death ed by the detached Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ፩ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 1 Yes 2 No 2 No Be 25. Was case referred to medical exampler? 26. Place of Death (Check only one) exammer? 1 Yes 2 ☐ No Hospital: Other: 1 VInpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28a Date (Injury 10/11/20/06 y Year) 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural after deeth.
I Director: Af
d in by the fur 21:30 1 ☐ Yes 2 ☑ Mo subject drove 2 Accident car into 10/12/06 6 Could not be determined 3 Suicide 6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) Show LownRd. & Gambril Location (Street and Number or Rural Route Number)

15 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 4 | Homicide peli 24 hours a 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number PIG Mum 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alcott Way #405, Owings Mills, MD 4600 Year) istrar's Signature State 2006 Registrar

Carolyn Loise Eades

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 35053

	R	- For State egistrar		Cen	tificate o	Deam					g. No		
Physicia	n/	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year 1.4.20 because						3 Time of Death 1430 hrs					
ledical Examin		Carolyn	Louise Eade	es						ctober 2	3, 2006 4c. County	of Dooth	
	1	4a. Facility Name (if not institution 8324 Quentin Street	on, give street and numb	per)		4b. City, Town, or Location of Death New Carrollton					Prince (
Funeral		5 Social Security Number	6. Sex 7.	Age (In yrs. la	st birthday)	If Under	1 Year	If Under 2	24Hrs8. I	Date of 8 in	th (MM/DD/YYY		thplace (State or Foreign
Director			1 M 2 X F	4.2	Yr	Months s.	Days	Hours	Min.	10/2	8/62	1	untry) ashington,DC
	H	578-90-7406 Usual Residence of Decedent		43						10/2	.0/02	W6	
any	_ h	10a. State 10b. County		10c City,	Town or Loca	ition							10d. Inside City Limits
<u>*</u>	٦	MD Prin	ce Georges	Nev	w Carr	olltor							1 X Yes 2 No
faryla 28a-f	Director	10e. Street and Number				10f. Zip C	ode		-	1	Og. Citizen of W	hat Cou	ntry?
ith the Maryland 23a or 28a-f show notified at once.	ă	8324 Ouentin	Street			20	784				United		
with ms 23 be no	uneral	11. Marital Status	12. Was Deced		S. 13. W	as Decedent Yes, specify	of Hispa Cuban, I	anic Origin Mexican, P	n? (Specify Puerto Ricar	Yes or No n, etc.)		e - Amer te, etc	ican Indian, 8lack,
death or ite	Fun		1 Yes	2 X No		1 v 0 -	- 1				Specify		_
s after ral",	ᆰ	3 XWidowed 4 Di	vorced If Yes, Give Year or Dates.	completed)	16a. Decede	Yes 2			nd of work o	done	Specify.		
5-0036 led within 72 hours after tygiene "matural", other than "matural", the Medical Examiner.	眶	Elementary/Secondary (0-12)			during	most of work	ng life. [OO NOT us	se retired)				
36 bin 72 than	Completed	12	2	,	Manao	ement	Spe	ciali	ist		Federa	a1 G	overnment
t-00 d with ygien ygien other	탉	17. Father's Name (First, Middle				<u>cinori c</u>	18	Mother's	Name (Firs	st, Middle, I	Maiden Surnam		× • • • • • • • • • • • • • • • • • • •
21215-0036 Juld be filed within 72 Mental Hygiene marked other inan event, the Medical) B	Albert Lee C	Clark					Mary	Digg	S			
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f shomatic event, the Medical Examiner must be notified at once	2	19a. Informant's Name/Relation	ship (Type, Print)								nber, City or To		
altimore, MD mit Pages and 2 sho ppartment of Health and poperant: If item 27 is jury or other traumat		Mary L. Clark	:/Mother	1 20h E	505 Place of Dispo				Drive Da		n Hill 20c. Location	- City or	20745 Town, State
S ar		20a. Method of Disposition 1 XBurial 2 Crematic	on 3 Removal from		crematory or o		, 01 00111	Citory,				,	,
Page Page ment clant:		4 Donation 5 Other S	Specify.		mony M	lem. N	at 11	Pk	10-31	L-06	Landor	zer,	MD ervices, P.A
Baltimore, MD 21215-003 permit Pages I and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other thingury or other traumatic event, the Med		21. Signature of Funeral Service	1 1 //		22.	Name and A	ddress (of Facility	Stric	klano	d Funera	al S	ervices, P.A
	-	23a. Part I. Enter the disease, of	or complications that cau	ised the death.	Do not enter	500 A the mode of	len dying, s	town uch as car	Road rdiac or resp	<u>Cam</u> ı piratory arr	Spring est, shock, or h	eart	MD 20/48 Approximate Interval
Physician /Medical		failure. List only one caus	e on each line	ensive ca									8etween Onset and Death
Examiner		Immediate Cause (Final diseas or condition resulting in death)	Due to (or as a c			Curar u	LSCas	<u> </u>					+
		Sequentially list conditions,	b										
	ner	if any, leading to immediate	Due to (or as a c	onsequence o	f):								
	Examiner	(Disease or injury that initiated events resulting in death) Last	C.	consequence o	f):								
ecuted			d				_						
rial rial	Physician/Medical	X UNPENDED	AMENDED	#23a,27,1	perME. g	862. 12	/5/06	TT					
8760, tificate bong physic as the bur	/We	IF FEMALE: 23b. Was decedent pregnant in		utcome of preg		Fetal death	3	Ectopic	pregnancy		23d. Date of Month	of delive	ry Day Year
Ox 68	ciar	past 12 months?	4 Pregna	nt at time of de		Other (Spec	Low		p9,		30		,
Box e death c the atten	ysi	1 Yes 2 No 9 🗸 U	a Olivilor										
P.O. Box 6 es that the death ce igned by the attend be detached for use	by Pt	Part II. Other significant cond	ditions contributing to	death but not r	esulting in the	e underlying	cause gi	ven in Par	t I				the cause of death?
S, P.C	q pe					-				24a Was			utopsy findings available
ords w requires se been should	plet									auto		prior to death?	completion of cause of
Reco	Completed									1 Yes		1 🗸 Y	'es 2 No
tal Rec cian: The certificate ector, page	Be C	25 Was case referred to medic examiner?	Description		1		- 1/	Othor:	Check only		1		
hysic hysic	To	1 Yes 2 No		patient 2	ER/Outpatie			y at Work?	Nursing Ho		Residence 6		er: Scene
n of ding Ph After t funeral		27. Manner of Death 1 X Natural 5 Pe	28a Date of (Month,	Day,Year)	20D Time C	of frigury 2		es 2		2. Describe	now injury occo		
Sior Attend death ector:	cati		vestigation	of Injury - At h	nome farm st	reet factory				Location	Street and Num	ber or R	ural Route Number, City
Division of Vital Records, pital or Attending Physician: The law requirt ours after death erral birector: After this certificate has been si filled in by the funeral director, page 2 should	Certification:	de	ould not be etermined (Specify)	or injury		, , , , , , , , , , , , , , , , , , , ,				or Town,			
Lospit 1 hour inners		4 Homicide 29a Certifier Certifying	Physician: To the best	of my knowled	ige, death oc	curred at the	time, da	te and plac	ce, and due	to the cau	se(s) and mann	er as sta	arted
Division of Vital Records, P.O. Box 6 To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death To the Finneral Director: After this certificate has been signed by the attendi completely filled in by the funeral director, page 2 should be detached for use	Medical	(Check only 1 Certifying one) 2 Medical Ex	xaminer:On the basis o	f examination a	and/or investi	gation, in my	opinion,	death occ	curred at the	e time, date	and place, and	due to	the cause(s)
To To	Mec	29b Signature and title of cert	and manner st	ateu.		290	License	number			29d Date sig	ned (M	onth, Day Year)
		1/1	11 Mi	× 12	(44)		O.C.1	∕I.E.			October 2	24, 200	06
(11)		30. Name and address of pers	on who completed caus	o leath (Item									
14/4		Theodore M. King, J	Jr., MD. Assista	nt Medical	Examiner	111 Pe	nn Str	eet, Bal	Itimore, N	MD 2120	1		
	tate	AAT 0 4 1	inne 🗗	gistrar's Signat	ure does	E)							
Regis	trar	OCT 3 0 2	UUO Bales	N M.	1				<u> </u>				

		•	for State Registrar	State	of Maryla		artment of I rtificate of		d Mental Hy	giene Reg. No. 20	06	35054
	Physici	an	1. Decedent's Name (First, Middle	-					2. Date of Do Month	Day	Year	3. Time of Death
	Physici /Medio			ntoinette		lla	I		Octob	er 17,	2006	8:15 P ^M
	Examir	er	4a. Facility Name (If not institution 5039 Harvard	. •	umber)		4b. City, Town, o		eath	4c. Count	y of Death	zont.
	Funeral		5. Social Security Number	6. Sex	7. Age (In yr	s. last birthday)	If Under 1 Year	If Under 24 H	Hrs. 8. Date of Bi	rth	Calv	place (State or Foreign
П	Funeral Director		218-34-6823	1 □ M 2 ½ F	68	Yrs.	Months Days	Hours N	Jul 1	ay, Year) 1938	Was	shington. Do
	g ,		Usual Residence of Decedent 10a, State 10b, County		100	City, Town or Lo	oation					10d. Inside City Limits
	faryla shov	ō	,	alvert	100.	St. Le						1 ☐ Yes 2151No
	28a-1	rect	10e. Street and Number		1		10f. Zip Code			10g. Citizen of	What Cour	ntry?
	3a or	O	5039 Harvard	Street			206	85			USA	•
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Itema 23a or 28e-f show eumatic event, the Medical Examinat must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Mar 3 ☒ Widowed 4 □ Divorced	Armed I	1 ☐ Yes 212 No			as Decedent of Hispanic Origin? (Specify Yes or No- Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes 2 X No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
ğ	2 hou	ted	15. Deceder	it's Education	w()	16a. Dece	dent's Usual Occu kind of work done	pation	working	16b. Kind of E	Business/In	dustry
21215-0036	thin 7	Completed	(Specify only highe Elementary/Secondary (0-12)		(1-4or 5+)	life.	DO NOT use retire	during most or d)	working	A.T.F		
7	ygien ygien her th			1		Gun	Tracer	10 11.15 4.1	Name (2011)			vernment
Maryland	ntal H	Be C	17. Father's Name (First, Middle, Salvatore	Last)		Carpi	no		Name <i>(First, Middle</i> p hin e	, maioen Suma	,	egrossa
2	should nd Me mark matic	은	19a. Informant's Name/Relations	ship (Type, Print)					Rural Route Numb	er, City or Town		
<u>β</u>	nd 2 salth ar 27 is r treu		Laura Baker ()	8042	Cardina	l Circle	e Lusby,	MD 20	657	
Baltimore,	of Hez of Hez fitem r othe		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation	3 DBamoval from		. Place of Dispo	osition (Name of matory or other pla		ct ^D 23	20c. Location	- City or To	own, State
Ĕ	Pag Iment tant: I		4 Donation 5 Other (5	Specify)	L	ee Crem			2006	Clint		
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked eny injury or other treumatic es one.		21. Signature of Funeral Service	Goff		81	25 South	ern Mar	Lee Funer yland Blv	d. Owi	Calv	
	Pnysician		23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition				nal ced lu			arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)		o (or as a cons		TOO TOO	3 amas				1 year
	ed	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Duat	o (or as a cons	equence of).					-	
ő,	ficate be executed physicien and is the burial-transit	I Exan	that initiated events resulting in death) Last	c. Due t	o (or as a cons	equence of):						
68760,	cate b physic the b	dical		d								
Division of Vital Records, P.O. Box 6	death certi e attending id for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ➡ No 9 □ Unknown	1 ☐ Live	outcome of preg birth 2 Fe gnant at time o	etal death 3	□Ectopic pregnand □ Other <i>(specify)</i> _	у			ate of delive onth	ery Day Year
ď.	that the dened by the a	y Ph	Part II. Other significant conditi	ons contributing to	death but not r	esulting in the u	nderlying cause gr	ven in Part I.	23e. Did	tobacco use con	tribute to the	he cause of death?
rds	n sign	ed by							1 🖪	Tes 2□No	3 🗆 Prot	pably 4 □Unknown
Reco	Physician: The law requires that the this certificete has been signed by the tall director, page 2 should be deteched.	Completed								ormed?	death?	ppsy findings available impletion of cause of
ta	an: T tificet tor, pa	0	25. Was case referred to medical	ıl				26. Place of I	1 ☐ Yes Death (Check only		1 🗆 Yes	2 □ No
<u> </u>	nysici nis cer direc	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 [Inpatient 2	☐ ER/Outpatier	nt 3 DOA Ot	hor	g Home 5 🗹 Res		her (Specif	·y)
27. Manner of Death 27. Manner of Death 1 Padural 1 Padural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 29c. Injury at Work? 20c. Injury at Work? 20c. Injury at North Nor							28d. Describe	how injury occu	rred			
Divis	al or Atte after des Directo d in by th	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 286. Pla	ce of Injury - At Iding, etc. (Spe	t home, farm, str ocity)	reet, factory, office			(Street and Num wn, State)	ber or Rura	al Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medicai C	29a. Certifier 1 Certifyin (Check only 2 Medical	ng Physician: To t Examiner: On the and ma	he best of my k basis of exami	knowledge, deat ination and/or in	h occurred at the t vestigation, in my	me, date and pl opinion, death o	ace, and due to the courred at the time	cause(s) and m date and place,	anner as s , and due to	tated. the cause(s)
	within To the	Me	29b. Signature and title of certifie				29c. Licen	se number		29d. Date signe		
)) acce					756024		October	- 18 5	760
	12		30. Name and address of person Lenneth L - All				Print) Sude 110	Prince	Frederick	HI) 20	178	
d.	Sta Regist			2 0 2006	Registra's Sig	gnature	Sperte)				

TOD: 30.00

Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible.
--	--------------------------------

			For State Registrar	State	of Marylar		artment of H		and Mental Hy	giene 0	06	35055
	Dhysisi	200	1. Decedent's Name (First, M	iddle, Last)					2. Date of D	Day	Year	3. Time of Death
	Physici /Medic		Mary	Franc		Flyr				per 26,		8:00 pm ^M
	Examin	er	4a. Facility Name (If not institu Homewood @	-			4b. City, Town, or Frede	erick	r Death		y of Death ederic	
	. Funeral Director		5. Social Security Number 026-18-9719	6. Sex 1 ☐ M 2 🛣 F	7. Age (In yrs. 83		If Under 1 Year Months Days	If Under a	24 Hrs. 8. Date of 8i Min. (Month, D Jul 22	1923	9. Birthp Cour Mass	place (State or Foreign htry) sachusetts
	aryland show	7	Usual Residence of Deceden 10a. State 10b. Cou Maryland Fre			ty, Town or Lo					1	0d. Inside City Limits 1 ☐ Yes 2 🏋 No
	with the M s or 28a-1 be notifie	Directo	10e. Street and Number 7401 Willow				10f. Zip Code	2 17 0	2	10g. Citizen of	What Cour	
36	n 72 hours after death with the Maryland "natural", or Items 23s or 28s-1 show citcal Examinar must be mulified at	by Funeral Director	11. Marital Status 1 Never Married 2 3 Widowed 4 Divor	12. Was Dec Armed F Married 1 Tyes If Yes G	2X No	i	Was Decedent of Hi If Yes, specify Cuba		gin? (Specify Yes or N , Puerto Rican, etc.)		ce - Americ ack, White,	
215-0036	- 30	Be Completed I	15. Dece	dent's Education ghest grade completed		(Give	dent's Usual Occupa kind of work done o DO NOT use retired	during most ()	of working	16b. Kind of 8		
2121	ed with	Сош		4+		Reg	istered Nu				Lth Ca	are
Maryland	should be filed within and Mental Hygiene. s marked other than "iumatic event, the Max	To Be	John Father's Name (First, Mid	rancis	Keaveny	<i>y</i>			r's Name (First, Middle lizabeth	e, Maiden Suma	Crow]	ley
\geq			John Francis						r o <i>r Rural Route Numi</i> r, Frederic			
altimore,	Pages 1 and 3 ient of Health nt: If item 27 ry or other tr		20a. Method of Disposition 1 🗷 Burial 2 ☐ Cremat 14 ☐ Donation 5 ☐ Othe		_	cemetery, cre	osition (Name of matory or other plac tion Ceme	e) tery	Oct 30,200	20c. Location Pisca	-	
Balti	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Sen	1111) MOO70				rd P.A. Fur			-d 21 7 01
	Physician		23a. Parti. Enter the disease shock, or heart ailure. Immediate Cause (Final disease or condition condition)	e, or complications that List only one cause on a	caused the dea	th. Do not en				arrest,	at y tai	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to	Corver Corver	quence of):	Heart	F	nline			year
8760,	certificate be executed iding physician an itse as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	å	o (or as a consec	quence of):						,
Bo	the death y the atter ched for L	Physician/Medi	IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 Live	utcome of pregn birth 2 Feta gnant at time of a nown	al death 3[□Ectopic pregnancy □ Other (specify)				ate of delive	ery Day Year
a	Se Go	by	Part II. Other significant con	ditions contributing to	death but not res	sulting in the u	inderlying cause give	en in Part I.		tobacco use coi Yes 2 X No		he cause of death?
8	The law ate has b page 2 sh	Completed							24a. Wa. auto perl 1 🗆 Yes		Were auto prior to co- death? 1 \(\text{Yes} \)	psy findings available mpletion of cause of
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to me examiner?	Hospital:			otho Otho		of Death (Check only			
of	Phys	1: To	1 Yes 2 No	1	Inpatient 2 e of Injury nth, Day Year)	ER/Outpatie 28b. Time o	11 3 DOA	402 NIVU	rsing Home 5 Res	idence 6 001 how injury occu		V)
ion	Attending Ph r death. ector: After th by the funeral	ation	1 Natural 5 Pe	nding (Mo restigation	nth, Day Year)	Injury		k? Yes 2⊟i	No			
Division	in the	ertification;	3 ☐ Suicide 6 ☐ Co	termined 28e. Place	ce of Injury - At h ding, etc. (Speci	iome, farm, st	reet, factory, office		28f. Location City or To	(Street and Num wn, State)	ber or Rura	al Route Number,
	Hospita 4 hours Funeral	edical C	29a. Certifier 1 Cert (Check only 2 Med	ifying Physician: To the ical Examiner: On the and ma	ne best of my kn basis of examin nner stated.	owledge, deal ation and/or in	th occurred at the time extigation, in my of	ne, date an pinion, dea	d place, and due to the th occurred at the time	cause(s) and n , date and place	nanner as s , and due to	tated, the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of ce	rtifier	-		29c. License	•	1	29d. Date sign	ed (Month, 27-06	Day, Year)
	15		30. Name and address of per	son who completed car	use of death (ite		51.0		twise t	he i	Sele	nle
	Sta Regist		31. Date filed (Month, Day, Y	(ear) 32.	Registrar's Sign		Corelle		, , ,	V - , /		

State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 11:41pm 5€ 2006 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dowell 125 Newtown Road If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1**⊠**M 2□F Yrs 216-09-7538 Maryland Director Feb 25, 1914 Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State 28a-f show th and Mantal Hygiene. 27 ie marked othar then "natural", or items 23a or 28a-1 shov traumatic event, <u>the Medical Evandr or must be notified at</u> 1 Yes 2 XNo Dowell Director MD Calvert 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20629 U.S.A. 125 Newtown Road death Funera 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after thent of Health and Mental Hygiene. Then of Health and Mental Hygiene. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Š Specify: Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Seafood House Laborer 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Florence Bean Alexander Gross ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 20 Dowell, MD 20629 Joseph Gross, Jr./son or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If eny Injury or once. 10/21/06 Lusby, MD St. John UMC Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Sewell Funeral Home 1451 Dares Beach Road Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence ettending physicien and for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed Exam Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 2 1 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 P No 1 Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 2 No Certification; To 1 Yeş 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Many of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Medical i 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number D. Hamse MOUNT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kioumarce Yazdani, M.D. Huntingtown, MD. 20639 31. Date filed (Month, Day, Year) 32. Registrat's Signature State 2006 Registrar

			1 - For State Registrar	State of M	larylan		artmen <i>tificat</i>			ind M	ental Hyg	iene	006	35057
7 6 . 4	Physic /Medi			Virgini		rdon					2. Date of Dea Month Oct.	20°,	2006	3. Time of Death 7:08 A ^M
(A)	Examir Funeral Director	ner	220-09-3753	Nursing	Cent	er last birthday) Yrs.	F	rede	eric If Under 2 Hours	k	8. Date of Birth (Month, Day May		$rac{ ext{Fred}}{ ext{Fred}}$	erick place (State or Foreign
	e Maryland Ba-f ehow	Director	Usual Residence of Decedent	rick	10c. City	y, Town or Lo	cation unsw	ick						10d. Inside City Limits 1 X Yes 2 ☐ No
9	72 hours after death with the Maryland natural', or Itama 23a or 28a-f ehow disal Examilian must be rutified at	Funeral	10e. Street and Number 416 W • B 11. Marital Status 1 □ Never Married 2 □ Married	St. 12. Was Deceden Armed Forces 1 Yes 2 5	?	1	Vas Decer f Yes, sper	21 dent of Hi city Cubar		gin? (Spe , Puerto F	cify Yes or No- lican, etc.)	14	USA Race - Ameri Black, White	can Indian, etc.
21215-0036	within ane. than	Completed by	3 ∰Widowed 4 □ Divorced 15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 7	Year or Dates ducation		16a. Deced (Give life.	dent's Usu	al Occupa rk done d se retired;	ition	of workin	g	16b. Kind	of Business/Ir wn hon	
Maryland	ould be fited Mental Hygi terked other tatic event, II	To Be C	17. Father's Name (First, Middle, Last) John Franklin	Moler					Emma	a Go	(First, Middle, I			
Baltimore, Mar	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke any injury or other traumatic once.		19a. Informant's Name/Relationship (Melody Marshal. 20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 6 □ 4 ☑ Conation 5 □ Øther (Specific	1 (Great	20b. P	e)122 Con et easan	Four sition (Nar radicy)r d t Vi	rth ne of other place	Ave	., B	3/06 S	ick, ^{20c. Loca} Jeff	MD 2 ution - City or To erson,	21716 own, State MD
Bail	Departition of the poor of the		mad.	21. Ignation of fund of Service Licensee 22. Name and Address of Facility Donald B. Thompson Funeral Home 31 E. Main St., Middletown, MD 21769 23a, Part1. Enter the disease, or complications that gaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate										
8760,	Physician /Medical Examiner the pnia-transit in pnia-transit	Ical Examiner	shock or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1 /.	s a consequence a consequence	uence of):	o Si	eve	u De	em	ecti	-		Interval Batween Onset and Death
P.O. Box 68	law requires that the death certifica as been signed by the attending ph 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 The loop of the lo	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3 [Ectopic pr Other (sp					230	d. Date of deliv	ery Day Year
	n requires that been signed b should be deta	Ď	Part II. Other significant conditions o	ontributing to death	but not resu	ulting in the u	nderlying c	ause give	n in Part I.		23e. Did tot	1	-	he cause of death?
tal Records,	The ite h	e Completed	25. Was case referred to medical									Peds Peds		psy findings available impletion of cause of
Division of Vital	ding Phys I. After this funeral dir	To B	examiner? 1 Yes 2 No 27. Manner of eath Natural 5 Pending 2 Accident investigation	28a. Date of Inj (Month, D	ury	ER/Outpatien 28b. Time of Injury		8c. Injury Work	r: 4 Nur	sing Hom	Check only on te 5 ☐ Reside 8d. Describe ho	ence 6		5)
Divis	in the	Certification:	3 Suicide 6 Could not be determined	288. Place of it	njury - At ho tc. (Specify	me, farm, str	eet, factory	, office		2	8f. Location (St. City or Town		Number or Rura	al Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	(Check only 2 Medical Exan	ysician: To the bes niner: On the basis and manner s	t of my know of examinat tated.	wledge, death ion and/or inv	occurred restigation	at the time, in my op	e date and inion, deat	l place, ar h occurre	nd due to the ca	ause(s) ar ate and pi	nd manner as s ace, and due to	tated. o the cause(s)
)	J \$ 5 8		29b. Signature and title of certifier	To MIC	> ,		290	D (+71	69	2	Jan Date s	1/23/2	Day, Year)
	×	17	30. Name and address of person who CHAN-HING	completed cause of	610	23a) (Type,	AV	E , 1	3RW	VSW	ick,	MO	21716	6
	Sta Registi		31. Date filed (Month Car), Yari3 2	UUb 32	uai s Signal	& A	mel	•						

Registrar

Grossnickle

Baltimore, Maryland 21215-0036

burial-transit P.O. Box 68760, for use as the funeral director, page 2 should be deteched certificate has After this

Division of Vital Records. within 24 hours after death.
To the Funeral Director: Al To the Hospital

1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 1200 pm Reda Anna Elizabeth Grossnickle ctobar 20 2000/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chapel Hill Nursing Home Randallstown Baltimore If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year Feb. 12, 1 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M 2X F 100 Yrs 220-18-2028 1906 Maryland Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d Inside City Limits or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. important: if item 27 is marked other than "natural", or items 23a or 28a-f show the figury or other traumatic event, the Medical Examiner must be notified at once. 1 Yes 2 No Director Maryland Union Bridge Frederick 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 10737 Green Valley Rd. 21791 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 **X**No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 Yes 2 XNo Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Leakins Effie Clabaugh ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) M. Louise Christoforo/ daughter 10609 Blue Bell Way Cockeysville, MD 21030 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Beaver Dam Cemetery 10/26/2006 nr. Union Bridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fymeral Service Licens 22. Name and Address of Facility Hartzler Funeral Home 6 E. Broadway Union Bridge, MD 21791 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Be Completed 1 Yes 2 No 3 Probably 4 Minknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 1 Yes 2 No Other: 4 Divursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - AI home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Park Heights Avenue Baltimore, MD 21208 7270 U6 borah 32. Regietrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes

Certificate of Death

35059

		1 - State Registrar	State of Maryla		artment of H tificate of L			iene g. No. 2006	35060
Physic /Medi		1. Decedent's Name (First, Middle, La: Spedden A	1ward Hause,	Jr.			2. Date of Deatl October	28ay 2006 ^a	3. Time of Death 11:30 PM M
Examir	ner	4a. Facility Name (If not institution, given Sunrise Assisted	Living of F		Freder			4c. County of De Frederi	
Funeral Director		5. Social Security Number 219-01-4317 6. S Usual Residence of Decedent	ex M M 2□ F 87	rs. last birthday) Yrs.	Il Under 1 Year Months Days	Hours Min.	May 24,	^Y 1919 Ma	irthplace (State or Foreign County) ryland
Maryland B-f show	tor	10a. State 10b. County Maryland Frederi		City, Town or Lo Frederic					10d. Inside City Limits 1 Yes 2 No
uth with the 23a or 28 ust be not	ai Director	10e. Street and Number 990 Waterford D	rive		10f. Zip Code 21702	2	10	Og. Citizen of What C	Country?
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: if Item 27 is marked other then "netural", or Items 23a or 28a-f show eny injury or other traumatic event, the Medical Examinar must be molified apprec.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Amoed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: WW	1	Vas Decedent of Hi Yes, specify Cubar ☐ Yes 2 No	spanic Origin? (Spe n, Mexican, Puerto Specify:	cify Yes or No- Rican, etc.)	nerican Indian, ite, etc. hite	
215-0 ithin 72 ho nen "netur Medical I	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	life. L	OO NOT use retired,	uring most of workii)	ng	6b. Kind of Busines	•
Maryland 21215-0036 d 2 should be filed within 72 hours aft th and Mental Hygiene. 77 is marked other then "netural", or traumatic event, the Medical Exemi	Be	17. Father's Name (First, Middle, Last) Spedden Alwar	d Hause. Sr.	Gener	ar rersor	nne1 Super	(First, Middle, M	Telephone	Company
Maryll	To	19a. Informant's Name/Relationship (1 Spedden A. Hause	уре, Print)	19b. Mailin 705 R	g Address (Street a Osemont A	nd Number or Rura	l Route Number.	City or Town, State, MD 2170	Zip Code)
altimore, mit. Pages 1 ac partment of Hee portant: if Item y injury or other		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State		sition (Name of statory or other place Crematory	" Oct. 30		oc. Location - City o	
Balt permit. Depart Imports eny inje		21. Signature of Funeral Service Licensee MO0255 MO0255 MO0255 MO0255 MO0256 MO0256 MO0257 MO02							
tificate be executed Examiner Examiner By hysicien and as the burial-transit as the burial-transit The provided as the burial transit f the burial transit of	al Examiner	23a. Part1. Enter the disease, or composition shock, or heart failure. List only disease or condition resulting in death) Sequentially list conditions, any sealing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a cons. Due to (or as a cons. Due to (or as a cons.	equence of):	or the mode of dying	i, such as cardiac o	r respiratory arre	st,	Approximate Interval Between Onset and Death 2 YRS
. Box death cer e attendir id for use	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	d. 23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of	etal death 3 1 death 5	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
Se do d	ρ	Part II. Other significant conditions co	entributing to death but not re			n in Part I.			o the cause of death? robably 4 (Abriknown
The the page	Completed	OSTEO ARTH	eits, E	3 P H			24a. Was an autopsy performe	24b. Were a prior to death?	utopsy findings available completion of cause of
OT VITAL Physician: 1 this certificet ral director, pr	Be	25. Was case referred to medical examiner?	Hospital:		Other	26. Place of Death	00000		
DIVISION OF t or Attending Physelfer death. Director: After this Jin by the funeral di	Certification; To	1 Yes 2 No 27. Manner ol Death 1 Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work? M 1 7	4 Unursing non	e 5 Residen 8d. Describe how	ce 6 Other (Spe	Living
DIVIS		4 Homicide determined	building, etc. (Spec	cify)			City or Town,	,	
To the Hospital of within 24 hours el To the Funeral Completely filled i	Medicai	29a. Certifier 1 ☐ Certifying Phyone) 2 ☐ Medical Examone) 29b. Signature and title of certifier	sicien: To the best of my k iner: On the basis of examinand manner stated.	nowledge, death nation and/or inve	estigation, in my opi	nion, death occurre	d at the time, date	e and place, and due	to the cause(s)
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		Donel			29c. License			Date signed (Mont October 30	
12		30. Name and address of person who c A DONG LSD 31. Date filed (Month, Day, Year)	mb 65c	アルか	med Go	MOSON	æ	FREX	RICK ZITOZ
Sta Registra	ar	NOV 0 3 2006	2. Begistrar's Sign	H Spare		7.4.			

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For Stete Registrar	State of M	laryland / Dep <i>Ce</i>	artment of F ertificate of			ene. g. No. 2006	35061
			1. Decedent's Name (First, Middle, Las	t)		, [2. Date of Death Month		3. Time of Death
	Physici /Medio		LYJA	M.		HUI	1ter	October	19 200	6 16:37 M
)	Examir		4a. Facility Name (If not institution, give	street and number,)	-	or Location of Dea	th	4c. County of Dea	ith
			5. Social Security Number 6. Si	HISP,+41	ge (In yrs. last birthday	BA/t/M	of C C i	N Data of Birth	None	
	Funeral Director			_ 37	54 Yrs.	Months Days	Hours Min		Year)C	thplace (State or Foreign ountry)
			Usual Residence of Decedent					0, 2, 7, 23.	7 1 11	эвтовтры
	nylan show	_	10a. State 10b. County	_	10c. City, Town or L					10d. Inside City Limits
	Ba-f a	Director	Md. Howa	rd	Col	umbia				1 ☐ Yes 2 X No
	with th	造	10e. Street and Number			10f. Zip Code	0.45	10	g. Citizen of What C	ountry?
	na 234	era	6519 Wingflash	Lane 12, Was Decedent	t Ever in U.S. 13	. Was Decedent of I	045 dispanic Origin? (1	Specify Yes or No-	USA 14. Race - Am	erican Indian
Maryland 21215-0036	a within 72 hours efter death with the Maryland Jiene. r than "natural", or liems 23s or 28s-f show the Madical Examiner must be notified at	by Funeral	1 ☐ Never Married ② ② ② ↑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces 1 Yes 2 1 If Yes, Give Year or Dates:	? No	If Yes, specify Cub	an, Mexican, Pue	Black, Whi		
Ö	72 ho	Completed	15. Decedent's Ed (Specify only highest gra			edent's Usual Occup e kind of work done		orking 1	6b. Kind of Business	/Industry
21	within 7 ene. than "r	nple	Elementary/Secondary (0-12)	College (1-4or 5+yrs	life	DO NOT use retire	d)	•		
2	filed with Hygiene. other than			5+yrs	EQU	acation S			Dept. of	the Army
and	o d a	Be	17. Father's Name (First, Middle, Last)				Neld	ime (First, Middle, M a Seal	aiden Sumame)	
Ž	d 2 should the and Men 7 is marke traumatic	2	Delous Smith Sr 19a. Informant's Name/Relationship (1)		19h Mai	ling Address (Street		lural Route Number,	City or Town State	Zin Code)
	2 8 2 8		Jerald A. Hunter					olumbia,Mo		<i>Esp</i> (3343)
ē,	- I = =		20a. Method of Disposition		20b. Place of Disp				Oc. Location - City or	Town, State
Ë	0 0 = =		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Metro Cre			21/2006	Catonsvill	e,Md.
Baltimore,	permit. Pag Depertment Important: I any injury o		21. Signature of Funeral Service Licen	S99	22010	22. Name and Addre	ess of FacilityHa	rrv H.Witz	ke's Fami	ly F.H.Inc.
8	80 5 5 8	1 "	undre P. C	mailo	MOO845 4	1112 Old (Columbia	Pike Elli	cott City	Md. 21043
н			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that cause one cause on each	ed the death. Do not el line.	nter the mode of dyi	ng, such as cardia	c or respiratory arres	st,	Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition resulting in death)	a MetAs	tatic 1	SLEAST	+ C	ANCER		Onset and Death
	/Medical Examiner		Todaking in country	Due to (or as	s a consequence of):					,
	4	<u>-</u>	Sequentially list conditions if any, leading to immediate	b. Due to (or as	s a consequence of):					
	d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	c.						
ó	cate be executed oblysicien and the burial-transit	EX	resulting in death) Last		s a consequence of):					
8760,	ate be hysici he bu	dical		d						
9	ing pl	Med	IF FEMALE:			× .			1	
.O. Box	at the death certificate be executed by the attending physicien and tached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 2 No 9 ☐ Unknown		2 Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of de Month	olivery Day Year
Δ.	that the		Part II. Other significant conditions c	ontributing to death	but not resulting in the	underlying cause on	ven in Part I.	23e. Did toba	acco use contribute t	o the cause of death?
ds,	requires that een signed b hould be deta	d by		•		, ,		1 ☐ Yes	2 10 No 3 □ P	robably 4 Unknown
S	w requir been si should	ete						24a. Was an	24h Were a	utopsy findings available
Vital Records,	The law ete has b page 2 sl	Completed						autopsy	ed? prior to death?	completion of cause of
ta		0	25. Was case referred to medical				26 Place of De	ath (Check only one		s 2 03 No
	lysici lis cer direc	ToB	examiner? 1 ☐ Yes 2 ØNo	Hospital:	ient 2 ER/Outpatie	ent 3 DOA Ot	200	Home 5 ☐ Resider		ecify)
Division of	Attending Physician: r death. ector: After this certific by the funeral director,		27. Manner of Death 1 ✓ Natural 5 ☐ Pending	28a. Date of Inj (Month, D	ury 28b. Time ay Year) Injury	Wo	rk?	28d. Describe how	v injury occurred	
isic	i or Attendi after death Director: A	licat	2 Accident investigation 3 Suicide 6 Could not be		njury - At home, farm, s		Yes 2 □No	28f. Location (Stre	et and Number or R	ural Route Number
Ω		Certification:	4 Homicide determined	building, e	tc. (Specify)	neot, ladidiy, olloo		City or Town,		ara riosto ilginoor,
	To the Hospital or within 24 hours after To the Funerel Direction completely filled in the	Medical (29a. Certifier (Check only one) 2 Medical Exem	ysicien: To the besiner: On the basis and manner s	t of my knowledge, dea of examination and/or i tated.	ith occurred at the ti nvestigation, in my	me, date and place opinion, death occ	e, and due to the cau curred at the time, dat	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	To the within 2 To the complete	Σ	29b. Signature and title ol certifier			29c. Licen:			d. Date signed (Mon	
			2 Moran	MD		Do	06448	33 0	thep 1	9. 2006
n	2	1 12	30. Name and address of person o	completed cause of	death (Item 23a) (Type	Print)	,	/.	4.0	7 7
V			Keith PRATZ 31. Date filed (Month, Day, Year)	40 /	//OR+L /2 trar's Signature	ROADW	Ay, BA	It. MORE	MD Z/	651
100	Sta Regista			2006	en &	Coule				9, 2006 231

State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** October 19 2006 5:02 P /Medical Tommie Lou Hahn 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Memorial Hospital Frederick If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year May 31, 19 Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 ☐ M 2 😡 F 215-36-5635 67 1939 Virginia Director Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits **ehow** rthen "naturel", or iteme 23a or 28e-f ehov the Modical Examiner must be notified at Frederick Frederick Maryland XXYes 2 No Director 10e. Street and Number 10f. Zip Code 21701 10g. Citizen of What Country? USA 405 Braddock Avenue death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Post Office Clerk permit. Pages 1 and 2 should be filed w Department of Heelth and Mental Hygier Important: If Item 271s marked other it eny injury or other traumatic event, ILIS 2006. other 17 Father's Name (First Middle Last) 18 Mother's Name (First Middle Maiden Sumame) Be Hester Maness Willie H. Miner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 405 Braddock Avenue, Frederick, Maryland 21701 Cindy Parks - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Mt. Olivet 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 10-23/2006 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service Licensee 1621 Opossumtown Pike, Frederick, Maryland 21702 arow ancele Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician espiratory /Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner ig physician and as the burial-transit The law requires that the death certificate be executed Condos Due to (or as a consequence of) Box 68760, IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No ģ Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a P.O. | 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 Probably 4 Unknown 1 Yes 2 No. Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete has autopsy performed 1 Yes 2 No 1 Yes 2X No Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗀 Yes 20 No 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1- Natural 5 Pending М 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours efter death To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide TI Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 9 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number October 20, 2006 Bookoul 21702 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) shah Hemen Tohnson 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State 2005 Registrar

Physicia /Medic Examin	a
Funeral Director	

permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Iteme 23a or 28a-f show any Injury or other traumatic event, If a Medical Exercical mast be cotified at angues. Once. Baltimore, Maryland 21215-0036

> Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effect death.

To the Funeral Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

For State Registrar	State of Marylar		artment of H tificate of L			gienę. Reg. No.		350	0
1. Decedent's Name (First, Middle, Last)				_	2. Date of De Month	eath Day	Year	3. Time of I	Death
Leonard M. Hunt					Octobe			4:00	a
4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, or	Location of Death		4c.	County of Death		
Montgomery Hospice- Ca				Rockville Montgomery					
577-28-8993	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Bir (Month, Da May 1,	ay, Year)		place (State or htry) ngton, D	
Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation		-		1	0d. Inside Cit	v I im
Maryland Montgomer								1 🗀 Yes	-
Maryland Montgomer Oe. Street and Number	у 5.	ilver Spr	10f. Zip Code			10a. Citi:	zen of What Cour	ntry?	
15201 Elkridge Way, #	1G		20906				USA	, .	
	12. Was Decedent Ever in U Armed Forces? 1 X Yes 2 No	J.S. 13. V	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No Rican, etc.)	0-	14. Race - Americ Black, White,		
3 Widowed 4 Divorced	If Yes, Give Year or Dates: 1942-	- 45	1 ☐ Yes 25€ No	Specify:			SpecifyWhite	d	
(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) (Give kind of work done during most of working life. DO NOT use retired)									
12		Centra	al Office Re				Communicat	ions	
17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)									
Hilda Warner									
19a. Informant's Name/Relationship (Type, Print) Helen T. Hunt/ Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15201 Elkridge Way, #1G, Silver Spring, MD 20906									
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetary, crematory or other place) Cate of Heaven Cemetery 20c. Location - City or Town, State October 24, Silver Spring, Maryland									
21. Signature of Funeral Service License	e C 0	F22	Name and Address				1 5.		
(hichen)	Lele		University				a MD 2000	17	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consection) Due to (or as a consection)								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown Part II. Other significant conditions cor	3c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown httputing to death but not re- e Disorder, Rena	al death 3 death 5 sulting in the un	Ectopic pregnancy Other (specify) nderlying cause give	n in Part I.			23d. Date of delive Month se contribute to the Man in	Day Y	
					24a. Was	an	24b. Were auto		vailal
					auto perfo	ormed?	death?		u 3ਈ (
25. Was case referred to medical examiner?				26. Place of Deat					
1 ☐ Yes 2 No	fospital: 1 Inpatient 2	ER/Outpatien	t 3 DOA Othe	r: 4 🗆 Nursing Ho	ome 5 Resi	dence 6	S ☑Other (Specif	Hospice	,
7. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investigation	28c. Injury Work M 1 1	at ? ′es 2 □ No	28d. Describe	how injury	y occurred				
3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, stre	eet, factory, office		28f. Location (City or To	Street and wn, State)	d Number or Rura)	l Route Numb	er,
29a. Certifier 1 S. Certifying Physical (Check only one) 2 Medical Exami	inion. To the best of my kn ner: On the basis of examinand manner stated.	owledge death ation and/or inv	conturned at the time restigation, in my op-	e, data and place inion, death occur	and dua to the red at the time,	causo(s) date and	and manner as at place, and due to	the cause(s)	
29b. Signature and title of certifier Cynitics M		,D,O.	29c. License	number 058032			e signed (Month,		6
30. Name and address of person who co Cynthia Williams, D.C				ville, MD 2	20855				
11. Date filed (Month, Day, Year)	32 Registrar's Sign	ature do	ude						

Stat Registra

5+1

Type of Fillit in black indelible link. Elisure All		
State of Maryland / Department of Health and Me	ental Hygiene 006	35064
Certificate of Death	Reg. No.	

			1 - For State Registrar	olato or marytane		rtificate of	Death		Reg. No.	00	00004
	División		1. Decedent's Name (First, Middle, Las	t)				2. Date of Dea Month		Year	3. Time of Death
	Physici /Medio		Duane Carl	Hajos					18, 20		2:40 a ^M
)	Examir		4a. Facility Name (If not institution, give	,			r Location of Death		4c. County	of Death	
			15606 Hackney La			L	Spring	Ţ		tgome	
	Funeral Director		5. Social Security Number 6. Sec. 215-54-6332 1 Usual Residence of Decedent	7. Age (In yrs. Ia M 2□F 56	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day Nov. 23	y, Year) 1949	Coun	lace (State or Foreign try) nington, Do
	land ow		10a. State 10b. County	10c. City	, Town or Lo	ocation				10	0d. fnside City Limits
	the Man 28a-1 et	Director	Maryland Montgom	ery Sil	ver S	oring			10g. Citizen of N	Albah Caus	1 ☐ Yes 2X☐ No
	23a or		15606 Hackney L			20906				USA	
900	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "natural", or Itame 23e or 28e-f ehow other traumatic event, the Modical Exertial must be notified at	d by Funeral	11. Maritaf Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Amed Forces? 1 □ Yes 2 图 No If Yes, Give Year or Dates:		Was Decedent of Hif Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)		e - Americ ck, White, d White	etc.
5-0	72 h natu	Completed	15. Decedent's Ed (Specify only highest grad	ucation de <i>completed)</i>	16a. Dece (Give	dent's Usual Occup	nation during most of work d)	king	16b. Kind of B	siness/Inc	dustry
121	within	dm	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired Machinis			II C	Des	.tal Camai
2	Hygie ther int,	ပိ	17. Father's Name (First, Middle, Last)			Machinis	18. Mother's Nam	ne (First Middle			stal Servic
ılan	Aental Aental rked o	To Be	Stephen Hajos					is Alice		,	erg
Maryland 21215-0036	and 2 should be filed within 'ealth and Mental Hygiene.'n 27 ls marked other then "ier treumatic event, the Me.		19a. Informant's Name/Relationship (7 Karen Lynn DeLeon			-	and Number or Run Court, Mc				
Baltimore,	permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is eny Injury or other treu		20a. Method of Disposition 1X Buriaf 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removaf from State	ace of Dispo metery, crea	sition (Name of matory or other place morial Park	Octol	Date ber 21,	20c. Location -	City or To	
Balt	permit. Pages: Department of H Important: If Ite eny Injury or of		21. Signature of Funeral Service Ligan	588 2	F1	ancis Adre 00 Univer	ss colorins	Funeral	Home T	nc.	, MD 20901
	Physician		23a. Part 1. Enjer the disease, or companies shock, of heart failure. List only of Immediate Cause (Final disease or condition	itications that caused the death one cause on each line.							Approximate Interval Between Onset and Death 6 Months
	/Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):						o months
	t insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ence of):						
68760,	rtificate be executed ng physician and as the burial-transit	Medical Exa	that initiated events resulting in death) Last	Due to (or as a consequent)	ence of):						
P.O. Box 68	se death ce the attendi hed for use	Physician/Med	fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. ff yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3[Ectopic pregnancy Other (specify)	,			te of delive	ry Day Year
rds, P.	w requires that the been signed by should be detact	þ	Part fl. Other significant conditions co	ontributing to death but not resu	iting in the u	nderlying cause giv	en in Part I.				e cause of death?
		Completed							rmed?	prior to con death?	osy findings available inpletion of cause of 2 No
/ita	Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?				26. Place of Dear				
₹ 	Physic this cral dire	ပ	1 ☐ Yes 2 📉 No			nt 3□ DOA Oth	4 Linuising no	ome 5% Resid	ience 6 □Oth	er (Specify)
ion c	Attending P r death. ector: After t by the funera	atlon:	27. Manner of Death 1 ⊠ Naturaf 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	28b. Time o Injury	Wor	yat k? Yes 2 □ No	28d. Describe h	now injury occur	red	
Division	s after de	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, str	reet, factory, office		28f. Location (S City or Tow	Street and Numb vn, State)	er or Rura	I Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier (Check only one) 11 Cartifying Ph 2 Madical Exam	ysician: To the best of my know iner: On the basis of examinati and manner stated.	vledge, deatl ion and/or in	n occurred at the tirvestigation, in my o	ne, date and place, pinion, death occur	and due to the orred at the time, or	cause(s) and ma date and place,	inner as sta and due to	ated. the cause(s)
	To the To the comple	Σ	29b. Signature and the of certifier	Dal		29c. Licens D2	e number 9675		29d. Date signe October		
			30. Name and address of person who calph Boccia, M.				thesda, M	ID 20817			
	Sta Registi		31. Date filed (Month, Day, Year) OCT 2 0 2	32 Registrar's Signat	ure do	enti					
CLU	VIII 17 Day 1/2	001	<u> </u>	, , , , , , , , , , , , , , , , , , , ,	-						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink

	riodoc rypo or rime in Black indonsio ink
Marcie Clarice Hagman	State of Maryland / Department of Health and Mental Hygiene

		For State Certificate of Death								Reg. No. 2006 2506					
Physicia	n/	Decedent's Name (First, Midd							Date of De		Yea	J U U3	Time-of Death		
Medical Examii		Marci		Hagman					October	Month Day Year 1840 hrs					
		4a. Facility Name (if not institution 20101 Rothberg Lane				4b. City, Town, or Location of Death Montgomery Village					-				
Funeral		5. Social Security Number	6. Sex 7. Age	e (In yrs. last birt	hday)	If Under 1 Year	_	T				Foreign			
Director		213-48-5068	1 M 2 X F	58	Yrs.	Months Days	Hours	Min.	Jan.	9,	1948	Count	_{ry)} Florida		
	ļ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location													
w any		10a. State 10b. County													
daryland 28a-f show 1 at once.	Þ	Maryland Monts 10e. Street and Number	gomery	Montgo	mery	Village							75		
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at once	Dire	10e. Street and Number 20101 Rothbury Lane, # 2101 20886							U. S. A.				.,		
ms 23	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Special Married Armed Forces?											n Indian, Black,		
death or ite	ᆵ	Yes 2 X No													
s after ral",	2		4 Divorced if Yes, Give Year or Dates:			Yes 2X No		ind of worl	, dona	16h	Specify:				
hour hour	ted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)								100.	. Kind of Bu	isiness/ind	ustry		
0036 within 72 iene. er than "	ompleted	Elemental yroecondary (0-12)	2 Years	,,,	Но	memaker					Over 1	l i			
5-00 led with tygiene other	S	17. Father's Name (First, Middle			1101		8. Mother's	s Name (Fi	irst, Middle	, Maide	Ac. County of Death Montgomery MM/DD/YYYY 9. Birthplace (State or Foreign Country) Florida 10d Inside City Limits 1 X Yes 2 No Citizen of What Country? U. S. A. 14 Race - American Indian, Black, White, etc. Specify White 3b. Kind of Business/Industry Own Home den Surname) 17, City or Town, State, Zip Code) 1840 hrs 1948 10d Inside City Limits 1 X Yes 2 No Citizen of What Country? U. S. A. 14 Race - American Indian, Black, White, etc. Specify White 3b. Kind of Business/Industry Own Home den Surname) 17, City or Town, State, Zip Code) 1840 rick, Maryland 21703 1960 Location - City or Town, State Falls Church, Va. L CHAPELS, INC. ILLE, MARYLAND 20852 Approximate Interval Between Onset and Death Death 23d Date of delivery Month Day Year 1940 Were autopsy findings available prior to completion of cause of death? 2 No 3 Probably 4 Unknown 1940 Were autopsy findings available prior to completion of cause of death?				
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Nathan Wasser	rman				Car	lyn (Gordo	n					
ID 21215-00; should be filed with and Mental Hygiene 77 is marked other thatie event, the Men	2	19a. Informant's Name/Relation:		19	b. Mailing	Address (Street					City or Tow	n, State, Z	ip Code)		
and 2 shou fealth and 3 ten 27 is r		Michael B. Car	rpel - Son	5	311	SAint May	wes C			der	ick, l	Mary1	and 21703		
W - +		20a. Method of Disposition 1 X Burial 2 Crematio	n 3 Removal from Str	crema	tory or oth	tion (Name of ceme er place)			ate	- 1		,			
imor Pages ment of tant: If		4 Donation 5 Other S		King	Davi	d Mem. Go	ins	10/2	7/06		Falls	Chur	ch, Va.		
Baltimore, permit. Pages I ar Department of Hee Important: If ite	- 1									MEMORIAL CHAPELS, INC.					
a a a a iii	_	Conald: Stattlemeser 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAN													
Physician		23a. Part I. Enter the disease, o failure List only one cause	r complications that causes on each line.	the death. Do n	ot enter th	ne mode of dying, s	such as ca	ardiac or re	espiratory a	rrest, s	hock, or hea	art	Between Onset and		
/Medical	i														
	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):														
	Examine	cause. Enter Underlying Cause c.													
ed nsit	Exa	events resulting in death) Last	Due to (or as a conse	equence of):											
execut in and I - tra	ledical	X UNPENDED	AMENDED								· · · · · · · · · · · · · · · · · · ·				
, P.O. Box 68760, res that the death certificate be executed signed by the attending physician and be detached for use as the burial - transit	ledi	IF FEMALE:	#23 23c. If yes, outcor	a.PII.27.	28a-f	penME G8	61, 1	1/30/0	6 TT_	12	23d Date of	delivery			
18760, rificate be ring physici as the buri	≥	23b. Was decedent pregnant in past 12 months?				tal death 3	Ectopic	pregnancy				Year			
Box 68 the death certing the attending and for use a		1 Yes 2 No 9 Ur	4 Pregnant at	41 6 1 11		ner (Specify)									
BC he dea	چ	Part II. Other significant condi	9 OHKIOWII	le terre e e e e e e e e e e e e e e e e			in Day		220 Die	Ltobacc	o usa saats	huta ta the	a source of death?		
that the detac					•	, , ,									
S, I	To Be Completed by	Theunoma, Type	ertensive athero	scierocic	Caru	LOVASCUIAT	diseas	se,	24a. Wa						
ords aw requi as been 2 should		multiple sclerosis, seizure disorder							aut	opsy formed	1	prior to con			
Rec The I									1 Yes		3	-	2 No		
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the raster death an Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact		25 Was case referred to medic examiner?	(Mospital:		_		of Death (Other _a	Check onl							
Physical directions		1 ✓ Yes 2 No	inpatie		Outpatient	o		Nursing F					cene		
ding ding l		27. Manner of Death 1 Natural 5 Per	28a. Date of Inju (Month, Day,) nding Fpd 10/2	(ear)	Time of I				sa. Describ	e now i	njury occurr	red			
Sior Attend death ector: by the	Certification:		estigation TIM 10/2	4/2006 Fn		Fire	es 2 X		unknow		t and Numb	er or Pura	Poute Number City		
Divi al or safter	ij	3 Suicide 6 X Could not be determined (Specify) residence								or Town, State) 20101 ROthberg Lane					
ospit.		29a Certifier 1 Certifying I	1	esidence	oth accur	rod at the time, dat	to and nla								
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certificate has been signed by the attending To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical		aminer: On the basis of exa												
To To	Mec	29b. Signature and title of certif	and manner stated ier		-	29c License	number			290	d Date sign	ned (Month	, Day.Year)		
16		Tanla la	Leen de	P		O.C.N	Л.E.			0	ctober 25	5, 2006			
		30. Name and address of person	on who completed cause of	death (Item 23a)									-		
		Tasha Greenberg MI	D. Assistant Medic	al Examiner		Penn Street, E	Baltimo	re, MD 2	21201						
	tate	31. Date filed (Month, Day, Year	32. Jegistra	ar's Signature	Ana	de la				-	-				
Regis	trar	OCT 3	1 2006	المر ري	1	2 - 152.8 T									

		State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2006 350									
Physicia		1. Decedent's Name (First, Middle, Last) Harold Brooks Hearn			2. Date of Dea Month	Day Year		3. Time of Death 13:58 P M			
/Medic Examin		4a. Facility Name (If not institution, give street and num	a Center		SAL	Location of Dear	h	111	y of Death	10	
Funeral Director		221-24-5121 ^{1⊠ M 2□ F}	7. Age (In yrs. last birtl	frs. Months	Days	If Under 24 Hrs Hours Min.		y, Year)	Cour	lace (State or Foreign itry) aware	
n the Maryland r 28s-1 ehow	ctor	Usual Residence of Decedent 10a. State 10b. County DE Sussex	10c. City, Town	or Location					1	0d. Inside City Limits 1 ☐ Yes 2 🖾 No	
ath with the 23a or 28 nat be not	rai Dire	10e. Street and Number 14413 Pepperbox Road	<u>-</u>		19940			U.S.	g. Citizen of What Country? U.S.A.		
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene, the mean 23e or 28e-1 show ant, the Mealical Examination must be motified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 【 Married 3 □ Widowed 4 □ Divorced 12. Was Dece Armed For 1 □ Yes, Giv Year or Day 13. Was Dece Armed For 1 □ Yes, Giv Year or Day 14. Was Dece Armed For 1 □ Yes, Giv Year or Day 15. Was Dece Armed For 1 □ Yes, Giv Year or Day 16. Was Dece Armed For 1 □ Yes, Giv Year or Day 17. Was Dece Armed For 1 □ Yes, Giv Year or Day 18. Was Dece Armed For 1 □ Yes, Giv Year or Day 19. Was	2 ☑ No e	13. Was Dece If Yes, spe 1 \(\subseteq Yes		spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	- 14. Ra Bla Speci	ce - Americ ack, White, fy:		
vithin 72 ho	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1		life. DO NOT u	ork done d se retired)	uring most of wo	rking	16b. Kind of E	Business/In-		
aryland 2 should be filed and Mental Hygi merked other umatic event.	To Be Co	9 Service Man Poultry 17. Father's Name (First, Middle, Last) Howard Hearn Service Man Poultry 18. Mother's Name (First, Middle, Maiden Surname) Mabel Hearn								J	
e, Mand 2 tealth a maz7 is		19a. Informant's Name/Relationship (Type, Print) Bernice Hearn (Wife) 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from 5	20b. Place of cemeter)	4413 Pe Disposition (Na y, crematory or	pperb	oox Road	Delmar Date	, DE 1	9940 - City or To	own, State	
Baltimore permit. Pages 1 Depertment of P Important: If ite eny injury or of		21. Signature of Funeral Service Licensee	Melsor	22. Name a Shor	nd Addres	s of Facility neral Ho	21, 200 me Delmar,		mar,	rii)	
S8760, Crate be executed Examiner bhysicien and bhysicien and sthe burial-transit	dicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	or as a consequence of	in columnial was	nte	Jiz c	discou			Approximate Interval Between Onset and Death	
Box (death certif	Physician/Medical	230. Was decedent pregnant 1 Live b	come of pregnancy irth 2 Fetal death ant at time of death own	3 □Ectopic p 5 □ Other (s					ate of delive	ery Day Year	
S, S, S, S, S, S, S, S, S, S, S, S, S, S		Part II. Other significant conditions contributing to de	eath but not resulting in	the underlying	cause give	in in Part I.	23e. Did to	obacco use cor res 2 No		ne cause of death? ably 4 Unknown	
	Completed by						1 Yes	rmed?	Were auto prior to co- death? 1 \(\subseteq Yes	psy findings available mpletion of cause of 2 No	
this Property of C	ation; To Be	25. Was case referred to medical examiner? Tyes 2 No								y)	
	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or City or Town, State)									
Div Div To the Hospital or # within 24 hours eliter To the Funcel Dire completely filled in b	Medical	29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of the time.									
		29b. Sign ture and title of centier 30. Name and address of person who completed caus	10/14	Date signed (Month, Day, Year) Plik (Db Libny Md 218 D4							
		DEL TRACTION AND AUGUSTESS OF DOTS OF WITHOUT CAUS	se of death_(Item 23a) (Type Dries				_			

			State of Maryland / Department of Health and 1- State State Certificate of Death	Mental Hygi	ien 2 () () 6	35067						
			1. Decedent's Name (First, Middle, Last)	2. Date of Death	eg. No.	3. Time of Death						
	Physici		2-2-5A	Month	Day Year	8:11 am						
	/Medio		CARRIE N/M/N HAMMONDS 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea	ath	4c. County of Death	10.10						
			Civista Medical Center La Plato		Char	les						
7	Funeral		5. Social Security Number 6. Sex 1 □ M 2 ▼ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hr Months Days Hours Mir	n. (Month, Day,	Year) Cou	place (State or Foreign intry)						
	Director		219-42-2878 87 ITS. Usual Residence of Decedent	APR.15	5,1919 VII	RGINIA						
	yland		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits						
	e Ma	ctor	MARYLAND CHARLES LA PLATA		1 □Yes X XNo							
U	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f ahow or other treumatic event, the Medical Examinar must be notified at	Funeral Director	10e. Street and Number 10f. Zip Code 20646	10	Og. Citizen of What Cou	ntry?						
(- .	sms 2	ner	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? Armed Forces? 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue	(Specify Yes or No-	14. Race - Ameri Black, White							
36	s after , or its	by Fu	1 Never Married 2 Married 1 Yes 2 No Specify:	ono moan, etc.,	0							
() 8	within 72 hours ene. then "neturel", he Medical Exe	ed b	3XXVidowed 4 □Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Business/Ir	HITE						
)	nin 72 na na	plet	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of well life. DO NOT use retired)	orking	Too. Talle of Besilious Industry							
10,72	filed with Hygiene other the	Completed	5 HOMEMAKER		OWN HO	4E						
land	be file tal Hy doth	Be		ame (First, Middle, M	faiden Sumame)							
Saryle	2 should be filed viand Mental Hygie is marked other reumatic event, II	၉	ARTHUR STEFFY MOLLY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or F		mber, City or Town, State, Zip Code)							
Z ⊆	nd 2 suith an alth an 27 is refu		NANCY OLIVER-DAUGHTER 9615 BEACH DRIVE, C									
e,	ss 1 and 2 of Health a litem 27 i		20a. Method of Disposition 20b. Place of Disposition (Name of		20c. Location - City or T							
A Limo	Page nent c ant: if ury or		XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) TRINITY MEMORIAL GDNS.1	0-27-06	WALDORF,	4ARYLAND						
Harm	permit. Pages: Depertment of H Importent: if ite any injury or ot		21. Signature of Funeral Service Licensee M00479 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A.									
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia	LAND 206 ac or respiratory arre	9.4.6 est,	Approximate						
			shock, or heart failure. List only one cause on each line. Immediate Cause (Final Branch of Cause or condition Presument Cause or condition Presument Cause or condition Presument Cause or condition Presument Cause or condition Cause or cause or			Onset and Death						
	/Medical		resulting in death) Due to (or as a consequence of):			4ays						
- 1	Examiner		Sequentially list conditions, b.									
18		nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									
W.	sicien and burial-transit	Examiner	that initiated events c									
68760,	cate be executed physicien and the burial-transit	dical	d									
89	rtifica ng ph	Medi	IF FEMALE:									
Вох	leath certifi attending	lan/I	23b. Was decedent pregnant on the past 12 months? 23c. If yes, outcome of pregnancy 1		23d. Date of deliv	ery Day Year						
P.O.	the de	Physician/Me	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown		MOHE	Day 19a1						
٥	es that the de gned by the be deteched	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	acco use contribute to t	he cause of death?						
rds	w requires been sig should be		Diabetes mellitus, coronary arterial	1 ☐ Yes	s 2 □ No 3 □ Prot	bably 4 Unknown						
ဝ၁	e law re has be	Completed	disease, hypertension, colon cancer	24a. Was an autopsy	24b. Were auto	opsy findings available ompletion of cause of						
<u>~</u>	ysicien: The l is certificate ha director, page	Соп	with colostomy	perform	ed? death?							
Vita	icien: sertific ector,	Be	examiner?	ath (Check only one								
of	Phys r this ral dir	. To		Home 5 ☐ Resider	nce 6 Other (Special	y)						
lon	th. : After the funeral	ition	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28b. Time of Injury Work? 1 □ Yes 2 □ No	280. 2630106 1104	williary occurred							
Division of Vital Records,	Atter er dea ector by the	ertification:	3 Surcide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stre City or Town,	eet and Number or Rura	al Route Number,						
Ō.	Itel or irs after ral Dir led in	Cert	John Grand									
	To the Hospitel or Attending Physicien: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending tompletely filled in by the funeral director, page 2 should be deteched for use es	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place and place and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place and manner stated.	ce, and due to the cau curred at the time, dat	use(s) and manner as s te and place, and due to	tated. o the cause(s)						
	To the within To the comp	ž	29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number	29	d. Date signed (Month,	Day, Year)						
			1. Sinarum D-006/1	014	10/22/06)						
	. 3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	0 11 0	Sall Write	dorf. MD						
6 8	Sta	te	Kavinder K Sinchumi 11350 pembrook Sch. 31. Date filed (Month, Day, Year) 32 Registrar's Signature	Suite :	504,	20603						
	Registr		NOV 0 2 2006 Julian & Sparke									

Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 0 6 35068 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death Physician OCTOBER 24, 2506 Harry Charles Hedrick 8:45PM /Medical 4c. County of Death Baltimore 4a. Facility Name (It not institution give street and number) Center 4b. City, Town, or Location of Death **Examiner** 6. Sex 1 M 2 ☐ F 8. Date of Birth March 24, 1919 If Under 1 Year | If Under 24 Hrs. 5 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 568-34-6132 Maryland 87 Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland. Department of Health and Mental hygiene. Important: If item 27 ie marked other then "nature!" ~ ... ery hijury or other treumatic ever 10a State 10h County 10c, City, Town or Location 10d. Inside City Limits MD Baltimore Parkton 1 ☐ Yes 2X No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 19417 Middletown Road 21120 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ZYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: Ď 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dairy Farming Dairy Farmer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Claudia Anna Hoover George Albert Hedrick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Hedrick/Wife 19417 Middletown Rd., Parkton, MD 21120 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition Pine Grove United Methodist Cemetery Oct. 30, 1

Burial 2 □ Cremation 3 □ Removal from State 2006 Parkton, MD 4 ☐Donation 5 ☐ Other (Specify) Signature of Eurieral Service Licenses 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. anass (Q. 24 Second St., New Freedom, PA 17349 en Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CARDIOGENIC SHOCK Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical ACUTE MYOCARDIAL INFARCTION Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner nding physicien and use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 DNo 3 Probably 4 Unknown Completed hes been 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No certificete or Attending Physicien: After this certification funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification; To 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Manner of Death 28b. Time of 28d. Describe how injury occurred Naturat 5 Pending deeth. 1 Tes 2 No 2 Accident investigation within 24 hours efter deeth To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 🔀 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D24034 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 7601 OSLER DRIVE TOWSON, TIMOTHY LOW M.D. MARYLAND 21204 31. Date filed (Month, Qay, Year) 32 Registrar's Signature State Registrar

		-	For State Registrar		State	of Mar	yland /		rtment of H			jiene leg. No 20	06	350	169
			Decedent's Name (First, Middle, Last)								th Day	Day Year 3. Time of Death			
	Physicia /Medic		W	/illia	am Fi	cankl	in_	Kir	ıg		Octobe:				a ^M
	Examin	_	4a. Facility Name (If no	ot institution,	give street and	number)			4b. City, Town, or	Location of Death			4c. County of Death		
			Joseph Ric							imore			n/a		
	Funeral		5. Social Security Num		6.Sex 172∑M 2☐F		(In yrs. last b	virthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Da) Jan 31	, Year) 1930	9. Birthpl County Mary	lace (State or try) Land	Foreign
	Director		215-38-772 Usual Residence of De			1	6				Jan Ji	, 1930	TRUL Y	Lana	
	yland		10a. State	0b. County			10c. City, To	wn or Lo	cation				10	0d. Inside Cit	<i>'</i>
	e Mar	ctor			rundel				Lothi	an				1 🗆 Yes	2 X No
	ours after death with the Marylan rel', or iteme 23a or 28a-f ehow Examinar must be motified at	by Funeral Director	10e. Street and Number 5931 Fishe	5co			10f. Zip Code 20711		10g. Citizen of V		try?				
	e 23a	era	11. Marital Status	ers so		ecedent Ev	ver in U.S.	13. \		ispanic Origin? (St	pecify Yes or No-	US 14. Rac	e - Americ	an Indian,	
' 0	fter d	Fun	1 Never Married	I 2 <mark>X</mark> Marn	Armed	Forces?)		Vas Decedent of H f Yes, specify Cuba		Rican, etc.)		k, White,		
936	filed within 72 hours after death with the Maryland Hygiene. uher then "naturel", or Iteme 23a or 28e-f ehow int, the Modical Examinat must be inclined at		3 Widowed 4	Divorced	If Yes, Year o	Give or Dates: 1	955–63	3	1 ☐ Yes 2 🔀 No	Specify:		Specify	whit	:e	
5-0	72 hours	Completed		5. Decedent only highes	s Education t grade complete	ed)	16	a. Deced (Give	tent's Usual Occup kind of work done o DO NOT use retired	ation during most of wor	king	16b. Kind of Ba	/siness/Ind	dustry	
12	within and.	mpl	Elementary/Secondary (0-12) College (1-4or 5+)						mer))		agric	ultw	re	
d 2	illed withing Hygiene. Other then		17. Father's Name (Fit	irst, Middle, I	Last)					18. Mother's Nan	ne (First, Middle,	Maiden Suman	10)		
Maryland 21215-0036	9 6 5 9	To Be	Lawrence	Wil}	kerson	King	ī			Alice	Elizak	eth W	<i>l</i> ard		
ary	2 should and Men ie merke		19a. Informant's Nam	e/Relationsh	nip (Type, Print)				ng Address (Street						
	end 2 Belth n 27 i		Ann Ford		wife				Fishers	Station					
Baltimore,	ges 1 t of H if iter or oth		20a. Method of Dispos 1 Burial 2 □		3 Removal fro	om State	ceme	tery, crer	sition (Name of natory or other place		Date	20c. Location			
15	it. Pa rtmen rtent: njury		4 □ Donation 5 21. Signature of Fune				Frie		ip Cemete		3-2006	Friends	'nτρ,	כוויז	
3/2 B	permit. Pages Depertment of the Importent: if ite any injury or of one.		William R. Cree Rausch Funeral Home, P.A., Owings, MD 20736												
119/06	Physician //Medical Examiner physician and physician and physician and physician strength	icai Examiner	23a. Part1. Enter the shock, or heart Immediate Cause (F) disease or condition resulting in death) Sequentially list cond if any, leading to immeause. Enter Underly Cause (Disease or in that initiated events resulting in death) La	failure. List inal littions, nediate ying	a	on each line to (or as a	consequence	e of):	MT 07	Flyny	?		<i>(4)</i>	Interval Beh	yeen Jeath
0/ 0. Box 68	The law requires thet the death certificate be executed site has been signed by the ettending physicien and pege 2 should be detached for use as the burtal-transit	Physician/Medi	IF FEMALE: 23b. Was decedent p in the past 12 m 1 Yes 2 9 Unknown	onths?	1 □ Lit 4 □ Pr	ve birth 2	of pregnancy Petal death	th 3[Ectopic pregnancy	y			ate of deliver		Year
i no	uires that signed b	5	Part II. Other signific	ant condition	ns contributing t	to death bu	t not resulting	g in the u	inderlying cause giv	ven in Part I.		obacco use con res 2 □ No	tribute to th		nknown
IRM Kir	law requir as been si 2 should l	Completed	Res	nal	111511	14 G)	MEN	CAN	,		24a. Was	an 24b.	Were auto	psy findings mpletion of c	available
چ ح	icien: The lav certificete has rector, pege 2	E O	18h	111/2	12/0	11	11/1	1/2/	113		perfo	rmed?	death?		2000 01
R.m. /ital F	cien: Brtifica Ictor,	Be	25. Was case referre	d to medica		7 11	1111				ath (Check only o		/	Ho.	/
- Jo	hysic this co	ြ	1 □ Yes 2 □	6		Inpatier				ner: 4 ☐ Nursing H		dence 6 Ooth	ner (Specif	MUST	100
, con	ding F	Ion	27. Manner of Death	5 Pendin	ig (/	ate of Injury Month, Day	Year) 200	o. Time o Injury	Wo	rk?]Yes 2∐No	280. Describe	now injury occur	100	1	
, (M) Division	Atten r deat ector: by the	fica	2 Accident 3 Suicide 4 Homicide	6 Could	not be 28e. P	lace of Inju	ry - At home,	, farm, st	reet, factory, office		28f. Location (City or To	Street and Numi	ber or Rura	al Route Num	iber,
وَ	tai or rs efte el Dir	Certification:	4 Normade		6	uilding, etc	. (Зреспу)				Ony or ro				
	To the Hospital or Attanding Physician: The I within 24 hours efter death. To the Funerel Director: After this certificete he completely filled in by the funeral director, page	Medical	29a. Certifier 1 (Check only 2 one)	Certifyin	Examiner: On the	the best on the basis of manner state	examination	dge, dea and/or ir	th occurred at the traversition, in my o	me, date and place opinion, death occi	, and due to the urred at the time,	cause(s) and m date and place,	and due to	tated. the cause(s	s)
_	To the within To the comple	₩.	29b. Signature and to	itle of certifie	- 1		1 / /	60	29c. Licens	se number		29d. Date sign	d (Month,	Pay, Year)	
	-		1 / IMAN	4 11	1/1/1	MU	1/1/		12	13012		10/1	916	10	
_	12011		30. Name and addre	ss of person	who completed	cause of de	eath (Item 33	аў (Тур	Print	al Al	1411	(de)	1/1/	1/2.	010
	10+1		31. Date filed (Month	Day Val	VIII	32 Registra	s Signature		WOW,	1 1101	113/11	77010	1//	1/10	10
	St Regist	ate rar	ST. Date med [MOHIII	OCT	2 0 200	6 /	Bours	K.	book	•					

DHMH 17 Rev 1/2001

Registrar

MOV 0 3 2006

DHMH 17 Rev 1/200

State

Registrar

3

Wiswayam

OCT 2 0

31. Date filed (Month, Day, Year)

October 16,200b

Mikhail LVOVSKIV

D64721

XXXVILLE

16/06

Mysician

32 Registrar's Signature

30. Name and address of perion who completed cause of death (Item 23a) (Type, Print) DR. VISWALINGAMI KANDAVE

LOCKS

State of Maryland / Department of Health and Mental Hygien 2005 35072 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** OCTOBER 20,2006 9:09A VALERIE MARIE LOPEZ-ROBINSON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 305 BARKSDALE AVE. WALDORF CHARLES Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 □ M 200 Months Days Hours APR.10,1990 MARYLAND Director 214-29-1453 16 Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10b. County 10a State or 28a-f show The Medical Examiner must be notified at 1 ☐ Yes 2 No Director MARYLAND CHARLES WALDORF 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a Completed by Funeral 305 BARKSDALE AVENUE 20602 U.S.A. 14. Race - American Indian filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Never Married 2 ☐ Married ŏ 1 Yes X No Specify: Baltimore, Maryland 21215-0036 Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 'naturel', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) STUDENT HIGH SCHOOL 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental Hitant: If Item 27 is marked other. Be ۵ GERARDO LOPEZ BERNICE ROBINSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Health in Item 27 I BERNICE ROBINSON-MOTHER 305 BARKSDALE AVE., WALDORF, MD 20602 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1 Department of H Important: If Ite eny Injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) TRINITY MEMORIAL GDNS.10-24-06 WALDORF, MARYLAND 21. Signature of Funeral Service Licensee M00479 RAYMOND FUNERAL SERVICE, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest, Approximate Interval Between Onset and Death OBU Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (vi as a consequence of) Examiner physician and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical 98 attending f IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 4 Pregnant at time of death o 9□ Unknown 9 Unknow á Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Tyes 2 No 3 TProbably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No 2 No Yes Division of Vital Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Inpatient 2 ER/Outpatient 3 DOA the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After the Hospital or Attending 5 Pending investigation Natural death. М 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2L Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 40 32, Registrar's Signature 31. Date filed (Menth, Day, Year) State 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 2006 35073 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) October 16, 2006 **Physician** 9:00 p M Patrick Michael Miles, Sr. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Frederick Calvert Calvert Memorial Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 13, 1932 9. Birthplace (State or Foreign Country) Maryland **Funeral** Months Days Hours 1**X**M 2□F 74 Yrs Director 577-42-1331 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State "natural", or Itama 23a or 28a-f show edical Examinar must be notified at 1 ☐ Yes 2 XNo Prince George's Brandywine Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20613 U.S.A. 16808 Croom Road Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No IYes, Give Year or Dates: 1952–56 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. white ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) The Ma Elementary/Secondary (0-12) College (1-4or 5+) painter construction 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Heelth and Mental Heart: If Itsm 27 is marked off jury or other traumatic even Be Evans William Michael Miles Lucy Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16807 Croom Rd., Brandywine, MD 20613 Brian A. Miles, son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Depertment Important: any Injury conce. MD Veterans Cemetery 10/24/2006 Cheltenham, MD 22. Name and Address of Facility Rausch Funeral Home, P.A. Surjure of Funeral Service Licenses 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** pulmonary embolus 3 days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the buriel-Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Day 5 Other (specify) 4☐Pregnant at time of death Ö 9 Unknown 9 Unknown Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ alzheimers disease 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? peripheral vascular disease 24a. Was an autopsy 1 Yes 2 No 2 X No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No ဥ his : After this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: s effer deau.
rei Director; Afr 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🖺 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours eft To the Funeral DI completely lilled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D 26358 October 17, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John/H. Weigel, M.D., 110 Hospital Rd., #310, Prince Frederick, MD 20678 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2 0 2006

			1 - For State Registrar	State of M	aryland		rtment of F		nd Ment	al Hygiei	ZUUh	35074
and the same of th	Physicia /Medic Examin	al	Decedent's Name (First, Middle, Lass Bertrand Odell Mi Aa. Facility Name (If not institution, give	chael)		4b. City, Town, o	r Location of	10	0 30	Day Year 2006 4c. County of Deat	3. Time of Death 7:15 A
	Funeral Director	CI	St. Vincent DePau 5. Social Security Number 6. Sr 217-30-1328 2		Cent ge (In yrs. Ia 74		Frostbu If Under 1 Year Months Days	rg, ME If Under 24 Hours	4 Hrs. 8. D. (A	ate of Birth Month, Day, Ye -23-193	ar) Co	hplace (State or Foreign untry) Y LAND
	he Maryland 28a-f ehow culfied at	ector	Usuat Residence of Decedent 10a. State 10b. County MD ALLEGANY 10e. Street and Number			Town or Lo				100	Citizen of What Co	10d. Inside City Limits XXXYes 2 □ No
36	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. do ther then "naturel", or teme 23a or 28a-f ehow do ther then "hydical Examinar must be notified at event, the Mydical Examinar must be notified at	by Funeral Director	201 EAST STREET 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedeni Armed Forces' 1 X Yes 2 U If Yes, Give Year or Dates:	? No		21532 Vas Decedent of H Yes, specify Cubi	lispanic Origi an, Mexican, Specify:	in? (Specify) Puerto Rican	UNI	TED STAT	ES ncan Indian, e, etc.
ณ	ad within 72 hour rgiene. er then "neturel" t, the Madical Ex.	Completed b	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5		16a. Deced (Give life. L	lent's Usual Occup kind of work done OO NOT use retired	during most o	_		Kind of Business/	,
⊑ _	should be filed and Mental Hygies marked other umarked other umarked other waste event, It	To Be	17. Father's Name (First, Middle, Last) JULIUS MICHAEL 19a. Informant's Name/Relationship (1)			19h Mailir	n Address (Street	E. FR	RANCES	BAER M		fin Code)
a)	1 end 2 s Health an tem 27 is other trau		ANNA MICHAEL/ WIF	'E	1 00	201 E	CAST STRE	ET, FR		RG, MD		
Baltimore,	permit. Pages Department of Important: If it eny injury or o		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen	see	ST.	22	EL'S CEM . Name and Addre OWERS FUN	ss of Facility		60	ROSTBURG, W. MAIN S ROSTBURG,	
X.	Physician /Medical Examiner		23a. Part1. Enter the disease, or composition of the control of th	one cause on each	ne. NCEO	Ł	er the mode of dyir		ardiac or resp	piratory arrest,		Approximate Intervat Between Onset and Death
8760,	law requires that the death certificate be executed as been signed by the ettending physicien and 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	b. Due to (or as								
P.O. Box 6	at the death certific I by the ettending parached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetat of	death 3	Ectopic pregnancy Other (specify)	<i>'</i>			23d. Date of deli Month	ivery 'Day Year '
ords, P	w requires that been signed t should be det	Ď	Part It. Other significant conditions o	ontributing to death	but not resut	ting in the u	nderlying cause gre	en in Part I.		23e. Did tobaco	_	the cause of death?
tal Rec	The ete h page	e Completed	25. Was case referred to medical					26 Place o	_	24a. Was an autopsy performed Yes 2	? prior to o	topsy findings available completion of cause of
Division of Vital Records,		ertification: To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		ury :	R/Outpatien 28b. Time of Injury	28c. Injur	er: 4 Nurs	sing Home 28d. [6 □Other (Specially)	cify)
Dİ	To the Hospitel or Attending Phymitin 24 hours slider death. To the Funeral Director: Aller th completely filled in by the funeral	O	3 Suicide 6 Could not be determined	289. Place of it	atc. (Specify)		eet, factory, office	no. tate and		City or Town, Si		
	To the Hos within 24 ht To the Fun completely	Medical	(Check only 2 Medical Examone) 29b. Signature and title of certifier	niner: On the basis and manner s	of examination	on and/or in	vestigation, in my o	pinion, death	occurred at	the time, date	and place, and due	to the cause(s)
	h		30. Name and address of person who				Print)	5532			x+ 30,	2006
	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 3 20		M Tentrar's Signatu	mace ure	Frosto	wig	M V21	532		

		1 - For Amend #26	State of Per Phy G	Marylar Marylar	3/06 Jap	artmei <i>rtifica</i>	nt of H <i>te of L</i>	ealth a D <i>eath</i>	and Mo	ental Hyg	giene Reg. No.	006	3507
Dharini		1. Decedent's Name (First, Middle, La	ist)							2. Date of Dea Month	Day	Year	3. Time of Dea
Physici /Medio		PAUL MAKOWSKI								OCTOBER	11, 2	2006	11:45
Examir		4a. Facility Name (If not institution, gir	e street and nun	nber)		4b. City	, Town, or	Location o	f Death		4c. C	County of Deat	h
		2329 BLUE VALLEY						ER SPF				MONTGOME	ERY
Funeral			Sex 1∭ M 2□ F	7. Age (In yrs.		Months Months	Days	If Under 2 Hours	Min.	8. Date of Birt. (Month, Da)	h y, Ye <i>ar)</i>	9. Birt	hplace (State or Fountry)
Director		219-32-8184 Usual Residence of Decedent		70	Yrs.	1				NOVEMBER	18,19	35 1	/ERMONT
and w		10a. State 10b. County		10c. Ci	ty, Town or L	ocation							10d. Inside City Li
Manyi f ehc	٥	MARYLAND MONTGOM	ERY			5	SILVER	SPRING	3				1 ☐ Yes 2 🛭
28a	Director	10e. Street and Number					ip Code				10a. Citiza	en of What Co	untry?
With Sa or		2329 BLUE VALLEY	DDTITE					20904				J.S.A.	•
within 72 hours after death with the Maryland ene. than "naturel", or iteme 23e or 28e-f ehow he Madical Exercites cast be collified at	Funeral	11. Marital Status	12. Was Dece		J.S. 13.	Was Dec	edent of H	spanic Orig	gin? (Spe	cify Yes or No-		4. Race - Ame	rican Indian,
riter	T.	1 ☐ Never Married 2 ☐ Married	Armed For	2 🗌 No		If Yes, sp	ecify Cuba	n, Mexican	, Puerto F	Rican, etc.)		Black, White	
al', o	Ď	3 Widowed 4 Divorced	If Yes, Giv Year or Da	e ites: VIETI	MAM	1 🗆 Yes	2 X No	Specify:			5	Specify: W	HITE
72 ho	Completed	15. Decedent's E (Specify only highest gi	ducation	-	16a. Dece			ation during most	t of workin	10	16b. Kin	d of Business/	Industry
Pan P	ple	Elementary/Secondary (0-12)	College (1	-4or 5+)	lite.	DO NOT	use retired)	OF WORK	<i>'</i> 9			
od wil	Ö		5+			CC	LONEL				Ţ	J.S. ARM	Y
be filed ital Hygie of other	Be (17. Father's Name (First, Middle, Las	t)					18. Mothe	r's Name	(First, Middle,	Maiden S	iumame)	
should bend marked marked umatic d	2	FRANCIS P. MAKO	WSKI						GENEV	IEVE TAB	ERSKI		
2 should be filed v n and Mental Hygie is marked other t raumatic event, th		19a. Informant's Name/Relationship	(Type, Print)		19b. Mail	ing Addres	ss (Street a	and Numbe	r or Rura	l Route Numbe	r, City or	Town, State, 2	Zip Code)
1 and 1 Health em 27		A. JOSELYN MAKOWS	KI - SPOUS	SE	2329	BLUE	VALLE	Y DRIVE	E, SIL	VER SPRI	NG, M	ARYLAND :	20904
of He		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3	TRamoval from 9		Place of Disp cemetery, cre	osition (Na matory or	ame of other plac	θ)	D	ate	20c. Loc	ation - City or	Town, State
Pages nent of I ant: If it ury or o		4 Donation 5 Other (Spec			T LINCO	LN CRE	MATORY	[10/16	/2006	BRENT	WOOD, MA	RYLAND
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iteme 23a or 28a-f show any injury or other traumatic event, the Madical Exhibiter must be publised at once.		21. Signature of Funeral Service Lio	nsee	Du		HINES.	RINAL	s of Facility DI FUNI AMPSHII	ERAL H	OME, INC	VER SI	PRING, M	ARYLAND 209
_		23a. Part1. Exter the disease, or cor shock or heart failure. List only	nplications that co	aused the dea									Approximate Interval Between
Medical Examiner bhysicien and the burial-transit	dical Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. ————————————————————————————————————	or as a conse	uence of								
The law requires that the death certificate site hes been signed by the ettending phypage 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		inth 2 ☐ Fet ant at time of	al death 3	⊒Ectopic ⊒ Other (s					23	3d. Date of del Month	ivery Day Year
puires than signed	Ď	Part II. Other significant conditions	contributing to de	eath but not re	sulting in the	underlying	cause give	en in Part I.			obaccous ∕es 2□		the cause of death
The law requirete hes been sipage 2 should	Completed											prior to death?	itopsy findings avai completion of cause
sien: ertific ctor,	Be (25. Was case referred to medical examiner?						26. Place	of Death	(Check only o	ne)		
g Physician: er this certificater, leral director, l	မ	1 Tes 2 No 27. Manner of Death	28a, Date	npatient 2 [of Injury th, Day Year)	28b. Time		28c. Injun			ne 5XXResid 28d. Describe I			cify) HOSPICE
Attending r death. ector: After by the fune	atio	1 Natural 5 Pending 2 Accident investigati		., Day . Ga.,	jury	М		Yes 2 □ I	No				
al or Atte after dei i Directo d in by th	ertification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 286. Place	of Injury - At I	nome, farm, s	treet, facto	ery, office		2	28f. Location (3 City or Tox	Street and vn, State)	Number or Ru	ural Route Number,
To the Mospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificete hes completely filled in by the funeral director, page 2	Medicai C	29a. Certifier 1 X Certifying F (Check only 2 Medical Expone)	hysician: To the miner: On the ba and mann	best of my kn asis of examin ner stated.	owledge, dea ation and/or i	th occurre	d at the tin in, in my o	ne, date an pinion, dea	d place, a	and due to the ed at the time.	cause(s) a date and p	and manner as place, and due	stated. to the cause(s)
To the within 2 To the complet	₹ E	29b. Signature and title of certifier	7,			2	9c. Licens	e number			29d. Date	signed (Mont	h, Day, Year)
F S F Ö		> EC Va	Alani	les			7	1810	1	1			
12		30. Name and address of person who	completed some	a of dant /l-	m 22a\ /T	Drine)	0	0,0	U		00	vova 1	1 5000
			RTOLAN	10	550	0 (COA	R L.	ARK	Co	LUM	SIA, A	7,2006
St Regist	ate rar		2006	egistrar's Sign	to do	we							

State of Maryland / Department of Health and Mental Hygiene 35076 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** October 26, 2006 George Wallace Meyer 1:50 AM M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Buckingham's Choice Health Care Center Frederick Adamstown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Jan. 21, Year) 923 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral X**XM 2□ F 83 New York 072-18-3536 Director Usual Residence of Decedent the Maryland 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location f Health and Mental Hygiene. Item 27 is marked other than "natural", or Itams 23s or 28s-1 show other traumatic avant, the Medical Examinar must be notified at 1 🗆 Yes 💥 No Frederick Adamstown Maryland Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? With 21710 U.S.A. 7072 Upland Ridge Drive Funeral filed within 72 hours after death Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 12. 2 □ No If Yes, Give Year or Dates: 1944–1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 14. Race - American Indian. 11. Markal Status Black, White, etc. 1 Never Married 2 Married Baitimore, Maryland 21215-0036 1 ☐ Yes 2\times No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Investment Broker Investments permit. Pages 1 end 2 should be file Deportment of Health and Mental Hy Important: if Item 27 is marked othin any liqury or other traumatic avent, size. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be George C. Meyer Jane Wallace ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Mrs. Anne S. Meyer, wife 7072 Upland Ridge Drive, Adamstown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Chesterfield Cemetery Oct. 30, 2006 Centreville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Reeney and Basford PA Funeral Home MOO255 106 East Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Metastatic Lung Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any, leading to include data cause. Enter Underlying Cause (Disease or injury Dire to (or as a nonsequence of): Examine or Attending Physician: The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) physicien Division of Vital Records, P.O. Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy Year Day 5 Other (specify) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ⊠Unknown icete hes been si page 2 should t Completed 1□Yes 2□No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2 No this certificete 2 No 1 ☐ Yes 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4MNursing Home 5 Residence 6 Other (Specify) Certification; To 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funaral Director: completely filled in by the 6 Could not be determined 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only one) tha 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) War October 26, 2006 MD D0058726 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5

DHMH 17 Rev 1/2001

State Registrar Ventric Ct

3000-D

32 Registrar's Signature

31. Date filed (Month, Pay, Year)

Myersville MD 21773

			1 - For State Registrar	State of Maryla	and / Dep	artme	nt of He	ealth and	-		3000	35077
		AL.		1	Ce	rtitica	ite of D	eath	l a Data et	Reg. No	2006	35077
9	Physici	an	Decedent's Name (First, Middle, Last, MONGED DEFINE						2. Date of Month	Da		3. Time of Death
à	/Medic		MONSERRETE N/I	M/N PUIG		4b. Cit	v. Town. or I	ocation of De	OCTO:		7 , 2006	
	Cxallill	iei		URT				DORF			CHARLE	
- A	Funeral		5. Social Security Number 6. Se:	x 7. Age (In yi	rs. last birthday)	If Und	ler 1 Year	If Under 24 H		Birth Day, Year,		nplace (State or Foreign untry)
¥	Director		081-54-1348 Usual Residence of Decedent	^{3M} 2X ^{3F} 88	Yrs.	1.000	5 54,5				18 PUEI	RTO RICO
	land		10a. State 10b. County	10c.	City, Town or Le	ocation						10d. Inside City Limits
	Mary Hear	tor	MARYLAND CHARL	ES W	ALDORE	7						1 ☐ Yes 2 🔀 No
^	th the	lred	10e. Street and Number			10f. 2	Zip Code			10g. Ci	tizen of What Co	untry?
	eth w	by Funeral Director	1106 STONE COUR					604			U.S.A	•
	lteme	une	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ▼No					(Specify Yes or erto Rican, etc.)	1	14. Race - Ame Black, White	
920	urs af	by F	XXWidowed 4 □ Divorced	If Yes, Give Year or Dates:		1 X Yes	2 No	Specify: PU	ERTO F	RICAN	Specify: WI	HITE
21215-0036	within 72 hours after deeth with the Maryland ene. then "neturel", or iteme 23a or 28a-1 show he Madical Examiner must be notified at	Completed	15. Decedent's Edu (Specify only highest grad	cation	16a. Dece	dent's Us	sual Occupat	ion iring most of v	working	16b. K	(ind of Business/	
7	ithin De.	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT	use retired)	ining most or P	ionnig			
	Hygie ther t	S	10 17. Father's Name (First, Middle, Last)		HOME	EMAK	1	18 Mother's N	ame (First, Mid		OWN SEI	LF
and	d be lental l	To Be	DON ANGEL PU	JIG					NTONIA			
Maryland	shoul nd M	F	19a. Informant's Name/Relationship (Ty		19b. Maili	ing Addre	ss (Street ar				or Town, State, Z	ip Code)
	and 2 alth a 127 is		GERARD TORRES-S	ON	3636	5 YO	RKTOW	N DRI	VE, WA	LDOR	F,MARYI	LAND20601
Baltimore,	of He of He or oth	N Ì	20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ F	20b Removal from State	p. Place of Dispo cemetery, cre	osition (N matory of	ame of other place,)	Date	20c. L	ocation - City or	Town, State
Ē	tment tant: tant:		4 □ Donation 5 □ Other (Specify)	SI	PETER	R'S	CH.CE	EM. 10	-21-06	WAL	DORF,MA	ARYLAND
Ba	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "neturel", or iteme 23a or 28a-f show amportant: or other traumatic event, the Modical Examiner mant be notified at once.		21. Signature of Funeral Service Licens		00479 ²							
	* *		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the dene cause on each line.	eath. Do not en	ter the m	ode of dying,	such as card	iac or respirator	y arrest,		Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	e Cerebra	Vascy	ler	dis	case				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cons	equence of):		11.6					
	de de	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a cons	equence of):	had	.11117	- (
18.	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Hypert	5 (40							
0,	e executed and and arrial-tr		resulting in death) Last	The state of the s		14						
8760,	icate be executed physicien and s the burial-transit	lical		345-1	10 cm	-						
Вох 6	death certific ettending pl	Physician/Med	IF FEMALE:	23c. If yes, outcome of pred	nancy							
Bo	etten f for u	clan	in the past 12 months?	1 Live birth 2 ☐ Fe 4 Pregnant at time o	etal death 3[Ectopic Other	pregnancy specify)				23d. Date of deli- Month	very Day Year
Р. О.	t the c by the	hysi	1 ☐ Yes 2 MNo 9 ☐ Unknown	9□Unknown			7/					
IS, F	Physicien: The law requires that the death certificate be executed this certificate has been signed by the ettending physicien and rail director, page 2 should be detached for use as the burial-transit	þ	Part II. Dther significant conditions con	ntributing to death but not r	esulting in the u	inderlying	cause giver	in Part I.	9		V	the cause of death?
Š	w require been sig should b	Completed							-	•		bably 4 Unknown
Records,	The taw cete has page 2 s	Пр							24a. W	Masan utopsy enforme#d2		opsy findings available ompletion of cause of
ta	icien: Th certilicete ector, pag	0	25. Was case referred to medical					26 Place of D	1 ☐ Ye	s 2D No		2 □ No
<u>=</u>	lysici lis cer direct	To B	examiner?	Hospital: 1 Inpatient 2	☐ ER/Outpatier	nt_3[] [Other		Home 5 R		6 Other (Spec	TSSUKI.
0 [ng Pt fter tr ineral	:uo	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	of	28c. Injury a Work?		28d. Descrit			LIVING
Sio	Attending or death. ector: After by the fune	catl	2 Accident investigation 3 Suicide 6 Could not be	<u> </u>		М		s 2 No		/=:		
Division of Vital	efter of Direct din by	Certification:	4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	t home, farm, str cify)	reet, facto	ory, office			n (Street ar Town, State		ral Route Number,
	To the Hospitel or Attending Physicien: within 24 hours elfer death. To the Funerel Director Affer this certific completely filled in by the funeral director.	edical C	29a. Certifier 17 Certifying Physic (Check only one)	sician: To the best of my k	nowledge, deat ination and/or in	h occurre	d at the time	, date and pla nion, death oc	ce, and due to t curred at the tin	he cause(s) and manner as d place, and due	stated. to the cause(s)
	To the h within 2 To the f complete	Med	29b. Signature and title of certifier	and manner stated.		2	9c. License	number		29d. Da	te signed (Month	, Day, Year)
	->-0		1 1 7 1				DOO	334	26	10	119/01	•
•	2		30. Name and address of p son which	pleted cause of death (II	lem 23a) (Type,	Print)	ive. F	OBOX	2665	, LAF		D 20646
666	sta ∜ Sta	te	B. LARRY JENK 31. Date filed (Month, Qax, Year)	32. Revistrar's Sic	nature &	1	N. I					
107	Registr	14	31. Date filed (Month, Day, Year)	2006 32. Redistrar's Sig	1 15 1	agas.	pine 9					

			- State St	of Marylan 861 11/2 0	d / Depa /06 ∰	rtment of F tificate of I	lealth and N <i>Death</i>	Mental Hyg ฅ	jiene leg. No. 200	6 35078
			Decedent's Name (First, Middle, Last)					2. Date of Dea Month		3. Time of Death
	Physici /Medic		Management					OCTOBE		1.4
\$	Examin		4a. Facility Name (if not institution, give street and	d number)	Ryan	4b. City, Town, or	r Location of Death	JUL E.	4c. County of De	eath
		4	MEMORIAL HOSPITAL			CUMBERI		To Date of Blad	ALLEGAN	
	Funeral		5. Social Security Number 6. Sex 1	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	, Year) 9. E	Birthplace (State or Foreign Country)
	Director	}	Usual Residence of Deserver	× 95	112			Mar 1	5, 1911	MD
	/land ow		10a. State 10b. County	10c. City	y, Town or Lo	eation				10d. Inside City Limits
	Man a-f sh ifled	to	MD Allegany		Cum	berland				1 □Yes 2 □No
	or 28%)irec	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	23a c	Funeral Director	113 F Elder Street				21502 hispanic Origin? (Si		USA	merican Indian,
	tems	nue	Arme	Decedent Ever in U. ed Forces?	S. 13. V	Vas Decedent of H f Yes, specify Cub	lispanic Origin? (S _l an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Al Black, W	
36	s afte	by F	If Ye	res 2 ☐ No s, Give or Dates: X	1	□Yes 2□No	Specify:		Specify:	
21215-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	edt	y 15. Decedent's Education		16a. Deced	ent's Usual Occup	pation	- 1	16b. Kind of Busine	white ss/n us ry
15	nin 72 .n "na Medic	Completed	(Specify only highest grade completed in the complete state of the	eted) ege (1-4or 5+)	(Give life. L	kind of work done OO NOT use retired	during most of wor d)	king		
212	d within giene. er than " the Mec	ĕ	40		home	maker			own-hom	Δ
g	be filed tal Hygi of other event, tl	Be (17. Father's Name (First, Middle, Last)		HOHIC	illakci	18. Mother's Nan	ne (First, Middle,	Maiden Surname)	G
yla	2 should be and Mental is marked aumatic ev	၉	Joseph O. Mellott 19a. Informant's Name/Relationship (Type. Print				Sarah	Ann (Cl	ay) Mellott er, City or Town, State	
Maryland	iges 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at)				_		
	1 and Health		Ronald Ryan 20a. Method of Disposition	SON 20b. F		B.E. Elder sition (Name of	Street	Cum	berland 20c. Location - City	MD 21502 or Town, State
סַר	Pages nent of I ant: If Ite		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal	from State	cemetery, crer	natory or other pla	1		·	
Baltimore,	permit. Pag Department Important: I any injury o		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee/	Hi		emorial Par . Name and Addre		11/2/200	6 Cumber	land MD
Ba	permit. F Departme Importan any injur	l d	1 MM SI	1/11		Scarpe	elli Funeral	Home, PA		
			23a. Part. Enter the disease, or complications skock, or heart failure. List only one cause	that caused the deat	h. Do not ent	er the made 8	rginia.Aven	ue: Gumbe	gland, MD 2	pproximate Interval Between
100	Physician	0.0	Immediate Course (Fleet	cardial I						Onset and Death
Ą	/Medical	Н		ie to (or as a conseq		1011				
	Examiner		b. Ath	erosclero		rdiovasc	ular Dise	ease		years
	アルを	iner	if any, leading to immediate cause. Enter Underlying	ie to (or as a conseq	uence of):					
	and and trans	Examine	Sequentiary list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ie to (or as a conseq	rience of):					
68760,	ficate be executed physician and streems the burial-transit	a		10 10 for do d oorlood	,401,00 01,1					
387	icate phys s the	dical	d							
Box (death certifi e attending d for use as	Physician/Me		s, outcome pf pregn		Te			23d. Date of	delivery
	death a atte	icia	in the past 12 months?	Live birth 2□Feta Pregnant at time of o		Ectopic pregnanc Other (specify) _	y 		Month	Day Year
0.	at the de by the a tached	hys	9 ☐ Unknown	Unknown						
s, P	res that igned be be det	by P	Part II. Other significant conditions contributing		-	nderlying cause giv	ven in Part I.			e to the cause of death?
ord	w requir been si should b	led I	Complete Heart Block v	rith Pacer	aker_			101	res 2 No 3	Probably 4 Unknown
or Vital Records,	The law requires that the ate has been signed by thogge 2 should be detache	Completed						24a. Was autop	sv prior	autopsy findings available to completion of cause of
= R		Con						perfo 1∐ Yes	rmed? deatl	
Vita	certific ector,	Be	25. Was case referred to medical examiner? Hospital:			Lou	nor'	ath (Check only o		
or	Phys this al dir	ပို	TIL Tes ZINO	1 ☐ Inpatient 2 ☐ Date of Injury	ER/Outpatier 28b. Time o	R 3LIDOA	4 LI Nursing F		dence 6 Other (S	Specify)
n		ion	1. Natural 5 ☐ Pending	(Month, Day Year)	Injury	Wo	rk?]Yes 2∐No	200. Describe i	low injury occurred	
Division	or Attending after death. Director: After in by the fune	lical	3 Suicide 6 Could not be 28e.	Place of injury - At h				28f. Location (S	Street and Number of	Rural Route Number,
Div	after after Dire	Certification:	4 ☐ Homicide determined	building, etc. (Speci	fy)			City or Tov	vn, State)	
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by		29a. Certifier 1 Certifying Physician:	To the best of my kn	owledge, deat	h occurred at the t	ime, date and place	e, and due to the	cause(s) and manne	r as stated.
	he Ho n 24 he Fu pletel	Medical	(Check only 2 ☐ Medical Examiner: On one) and	manner stated.	alion and/or ir			urred at the time,	date and place, and	ude to the cause(s)
	To the within To the comple	Ž	29b. Signature and title of certifier	1 .		29c. Licens	se number		29d. Date signed (M	
	7		* Sellini	20.		D00	17505		OCTOBER 3	2 2006
	H		30. Name and address of person who complete				ATTATE N	m 21502		
	\		ANTHONY BOLLINO, M.D. 31. Date filed (Month, Day, Year)	922 NATI			LAVALE, M	W 21302		
	St Regist	ate rar	HOV 0 3 2006	32 Registrar's Sign	y So	Wil.				
			MATA A ST TOOL	STATE OF THE STATE	- 1					

State of Maryland / Department of Health and Mental Hygien 2006 35079 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Mary Vitalian Rothenburg October 18 2006 1300 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll Hospital Center Westminster
If Under 1 Year | If Under 24 Hrs. Carroll 8. Date of Birth (Month, Day, Year) Aug 05 1920 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1□M 2□F Yrs. 220-09-6431 86 Director Usual Residence of Decedent 10c. City, Town or Location 10b County 10a. State 10d. Inside City Limits or 28e-f show traumatic event, the Madical Examiner must be notified at Yos 2 No Director MD Carroll Westminster 10g. Citizen of What Country? 10e. Street and Number 510 Tremont Drive Apt 1 21157 USA itema 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Marned ŏ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 XNo Specify: ģ 3 ₩idowed 4 Divorced White "natural", Completed 16a. Decedent's Usual Occupation 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Coflege (1-4or 5+) Elementary/Secondary (0-12) Medical Secretary Wilmer Eye Clinic permit. Pages 1 and 2 should be file Department of Health and Mentai Hy importent: if flem 27 is marked othe eny injury or other traumests 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Emile Brossoit Margaret Kane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret E. Vitale/Daughter 30 Bella Vita Ct., Unit 2B Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/23/2006 Baltimore, MD Parkwood Cemetery 21. Signature of Funeral Service Licencee Prices funerar Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Pdr.1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) artery COVONOVU /Medical Due to (or as a consequence of): Examiner the Dentens in Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury Due to (or as onsequence of): Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 the attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Winknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed: 1 ☐ Yes 2 ☐ No 1 🗆 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.
To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No eral Director: After this of filled in by the funeral directors. 7 2DER/Outpatient 3□ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 2 Accident s after death. 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \ Homicide 1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c License number 29d. Date signed (Month, Day, Year) 100 DOD 50 763 MJL DR. Ernesto Mendecki VVI. 2 30. Name and address of person who completed cause of death (I -m 23a) (Type, Print) 5 Westmort 21157 ERNESTO MENDOZA, M.D. Rd 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2006

State of Maryland / Department of Health and Mental Hygien) 16

	•	For State Registrar	State	of Marylar	nd / Depa	artment of I rtificate of	Health a <i>Death</i>	and Me		iene	006	351	080
		1. Decedent's Name (First, Middle	, Last)					1	2. Date of Death		Year	3. Time	of Death
Physicia /Medic		Valerie Mary Rea	ed						Month October	18,	2006	2:59	рм
Examin		4a. Facility Name (If not institution,	give street and nu	mber)		4b. City, Town,	or Location of	of Death		4c. C	County of Deat	h	
		Shady Grove Adver 5. Social Security Number	ntist Hospi	tal 7. Age (In yrs.	last highday		cville	24 Hrs.	8. Date of Birth		Montgome	ery hplace (State	or Foreign
Funeral Director		579–38–4165	1□M 2 F	7. Ago (III)13.	76 Yrs.	Months Days		Min.	(Month, Day, uly 31, 1		Co	untry)	
		Usual Residence of Decedent							or, 51, 1	.550	· iasina		
anylan	Ļ	10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation						10d. Inside (City Limits s 2x No
Pe Ma	Directo	Maryland I	Montgomery		Silver	Spring				On Cities	en of What Co		3 2 <u>K</u>]110
with t		15115 Interlacher	n Drive #2	വാ		10f. Zip Code	20906		1	og. Cilizi	USA	untry?	
1215-0036 within 72 hours after death with the Maryland ene. then "naturel", or items 23e or 28e-f ehow the Mudical Examiner must be notilised at	Funerai	11. Marital Status	12. Was Dec	edent Ever in U	J.S. 13.	Was Decedent of If Yes, specify Cub		gin? (Spec	ify Yes or No-	14	4. Race - Ame		
or Ite		1 Never Married 2 Marri	Amed For ad 1 ☐ Yes If Yes, Gi	2 X No	-	If Yes, specify Cub 1 ☐ Yes 25€ No		n, Puerto H	ican, etc.)		Black, White Specify: Whit		
1215-0036 ithin 72 hours af ne. hen "naturel", or Medical Exam	d by	3 ☐ Widowed 4 ☐ Divorced	Year or E	Dates:									
15-1 15-1 172 i	iete	15. Decedent (Specify only highes			(Give	dent's Usual Occu kind of work done DO NOT use retire	durina most	t of working	g	16b. Kind	d of Business/	Industry	
within then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		e r k	30,				Banking		
ING 21215-0036 be filed within 72 hours after death with the Marylar ital hygiene. d other then "naturel", or lieme 23e or 28e-f ehow event, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle, I	.ast)				18. Mothe	er's Name	(First, Middle, N	Maiden S			
aryland 2 should be filed and Mental Hygi s marked other umatic event,	To E	Arthur Orme						Mary (Grace Par	sley			
Ma 2 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1		19a. Informant's Name/Relationsh Judy A. Rollins/	, , , ,			ng Address <i>(Stree</i> 28th Street				-		(ip Code)	
altimore, I mit. Pages 1 an partment of Heel portant: if Item 2 y Injury or other		20a. Method of Disposition 1 🕱 Burial 2 Cremation 4 Donation 5 Other (Sp		State	cemetery, cre	osition (Name of matory or other pla National Ce	,	Nov. Da			ation - City or		
Baltimo permit. Pag Department Importent: It any Injury o		21. Signature of Funeral Service I		^		2. Name and Addr					con, virg	Julia	
m ggggg		1 (tirchein	XLO	le		oncis J. C Universi					ng, MD 20	901	
*		23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final	complications that	caused the dea each lines	th. Do not en	ter the mode of dy	ing, such as	cardiac or	respiratory arre	est,		Approxima Interval Be Onsetean	etween
Physician /Medical Examiner		disease or condition resulting in death)	a. Due to	(or as a consec	quence of):	v fon	yilli		-/			min	les
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to	(or as a consec	1 1	ravery	K		1				
. Box 68760, death certificate be executed e ettending physicien and nd for use as the burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a consec	nc (quence of):	obstri	nctn	· pr	eling	Di	Serie		
8760 cate be e chysicien the buris	dicai		し d								ŧ		
ng phy as th		IF FEMALE:											
Box 68 leath certific ettending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live	atcome of pregn birth 2 - Feta	aldeath 3[⊒Ectopic pregnand	су			23	3d. Date of deli Month	very	Year
O. the de:	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐ Preg 9☐ Unkr	nant at time of one	death 5[Other (specify)					77101111	Juy	104
Records, P.O. The law requires that the de ste hes been signed by the e bage 2 should be detached it		Part II. Dther significant condition	ns contributing to d	death but not re	sulting in the u	ınderlying cause g	iven in Part I.		23e. Did tob	acco us	e contribute to	the cause of	death?
rds quires and blu	d by								1 ⋌ Ye	s 2 🗆	No 3□Pr	obably 4]Unknown
s been si	piete								24a. Was ar		24b. Were au	topsy finding:	s available
Rec The lav	Completed								autopsy perform	ned?	prior to death? 1 ☐ Yes	-1	cause of
Vital Records, stcien: The law requires to certificate has been signe lirector, page 2 should be on	Bec	25. Was case referred to medical examiner?					26. Place	of Death	(Check only one				
Vision of Vital Re Attending Physicien: The la r death. ector: Atler this certificete hes by the funeral director, page 2	ို	1 ☐ Yes 2 No		Inpatient 2		III JUDON			e 5 Reside			cify)	
on C	ion:	27. Manner of Death 1 Natural 5 Pending	9	of Injury oth, Day Year)	28b. Time o Injury	We		1	8d. Describe ho	w injury	occurred		
Division of to Attending Phy after death. Director: After this in by the funeral d	icat	2 Accident investig	ot be 200 Plac	e of Injury - At h	nome farm st	M 1 []Yes 2□		Bf. Location (Str	reet and	Number or Ru	ral Route Nu	mher
는 유럽는 E	Certification:	4 Homicide determine	ned build	ling, etc. (Speci	ify)	reet, raciony, onice			City or Town		774111201 01 774		
To the Hospital within 24 hours a To the Funerel I completely filled		29a. Certifier 1 Certifyin (Check only 2 Medical I	g Physician: To th Examiner: On the l	e best of my kn	owledge, dear	th occurred at the toyestigation in my	ime, date an	id place, an	nd due to the ca	iuse(s) a	and manner as	stated.	(s)
To the P within 24 To the F complete	Medicai	one) 29b. Signature and title of certifier	and mar	nner stated.		20c Licen	se number		200	od Date	sinned (Mont)	Day Vens	(6/
F 30 00		2	Luna	olv.	CIM	Di	062	242	5	10	1181	2001	
1>		30. Name and address of person	who completed cau	ise of death (Ite	m 23a)_(Type	Print)		1					410
		9715 Ned	le Chil	& Dr	Roc	Kuille	ANI D)/	Sorye	2	6154	7731	O, IMI
Sta Registr		31. Date filed (Month, Day, Year) OCT 2 0	who completed cau	Registrar's Sign	ture	ale							y

			For State	State of	f Marylan	d / Depa	artment of H	ealth ai	nd Me	ental Hy			5 3	5081
		•	Registrar 1. Decedent's Name (First, Middle,	l act)		001	tilleate of L			2. Date of D	Reg. No eath).	3.	Time of Death
Phy	sicia		Ricardo Rosado							Month	Da		ır	2:00 P M
	edic		4a. Facility Name (If not institution,		mher)		4b. City, Town, or	Location of	Death	0ct	16	2006 County of Di		2.00 +
Exa	mine	er l	21860 Eden Alle									Somer	set	
Fune	ral			. Sex	7. Age (In yrs. I	ast birthday)	Eden If Under 1 Year	If Under 2		8. Date of B	irth (9. 6		State or Foreign
Direc			581-26-4314	1 ∑ M 2□ F	76	Yrs.	Months Days	Hours	Min.	(Month, D Oct 2!				Rico
ъ.			Usual Residence of Decedent		10.00	_							404 1-	-id- Oh-Limbs
larylan show	1	_	10a. State 10b. County			r, Town or Lo	cation							iside City Limits ☐ Yes 2 ☑ No
the Mi		Director		erset	EC	len								
ours after death with the Maryla al', or Itama 23a or 28a-f shov			10e. Street and Number 21860 Eden Aller	n D-3			10f. Zip Code				10g. Ci	tizen of What	Country?	
s 23		Funeral			edent Ever in U.	S 12	21822 Was Decedent of Hi		in2 /Sno	oilu Vae or N	10-	USA 14. Race - A	merican Inc	dian
ltan		Š	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	Armed F		1 -	f Yes, specify Cuba	n, Mexican,	Puerto F	Rican, etc.)		Black, W		anari,
irs at		þ	3 XWidowed 4 ☐ Divorced	If Yes, G Year or I	ive	4	1X Yes 2□ No	Specify:	Puer	to Ric	can	Specify:	White	
tiled within 72 hours after death with the Maryland Hygiene Hygiene "Anturel", or Itema 23a or 28a-1 show			15. Decedent's			16a. Dece	dent's Usual Occupa	ition	-6		16b. K	(ind of Busine	-	
hin 7	Table 1	Completed	(Specify only highest Elementary/Secondary (0-12)		1-4or 5+)		kind of work done of DO NOT use retired		or workin	ig				
gien th		5	3rd	3			Farmer	:				Self-e	mbjo	red
al fig		Be (17. Father's Name (First, Middle, La	ist)				18. Mother	's Name	(First, Middl	e, Maider	Sumame)		
2 should be filed within and Mental Hygiene.		2	Ricardo Rosado,	Sr.				Tona	Car	dona				
s 1 and 2 should be filed within 72 hc f Health and Mental Hygiene.			19a. Informant's Name/Relationshi			19b. Maili	ng Address (Street a	and Number	or Rurai	Route Num	ber, City	or Town, State	e, Zip Code	e)
and and lealth m 27		-	Shirley Paulk/n	iece	20h B		Castle St	., Sa		oury, N		804 ocation - City	or Tours C	· · · · · · · · · · · · · · · · · · ·
Peges 1	5		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3	Removal from	State	emetery, crei	matory or other place							
I. Pe tmen tant:	dan		*4 □Donation 5 □ Other (Spe		Spr		1 Memory			/2006		lisbur	y, MI)
permit. Peges 1 an Department of Heal Important: if tem 2	DUCE		21. Signature of Funeral Service Li	onso		I	Name and Address Name and Address	latson Rd.	Fun Sali	eral H sbury	iome MD	21801		
100	-		23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that	caused the death							21001		roximate rval Between
Physici	ian		Immediate Cause (Final disease or condition			M	T (MY	OCAR	DIAL	TAT	ARCT	(UN)	Ons	et and Death
/Medi	cal		resulting in death)	a. Due to	(or as a conseq	uence of):							1	-
Examir	ner		Sequentially list conditions,	b		A5 (VD							
D 5		Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conseq	uence of):								
ecute and	-trans	cam	that initiated events resulting in death) Last	c	(or as a conseq	uanaa af):							-	
The law requires that the death certificate be executed to has been signed by the attending physicien and	puriai	E		Due to	(OI as a COIIseq	derice or).								
cate	90.	dicai		d										
v requires that the death certific	88 93	Physician/Me	IF FEMALE:	23c. If yes, or	atcome of pregna	incy						23d. Date of	delivery	
Beath cert attendin	101	clar	23b. Was decedent pregnant in the past 12 months?	1☐Live	birth 2 Feta	Ideath 3	Ectopic pregnancy Other (specify)					Month	Day	Year
the d	cue	Jys	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unki	nown									
s that	100 6	by PI	Part II. Other significant condition	s contributing to	death but not res	ulting in the u	nderlying cause give	en in Part I.		23e. Did	tobacco	use contribute	o the cau	use of death?
w requires to been signed	g B									1	Yes 2	!□No 3□	Probably	4 Unknown
taw requires tas been si		Completed								24a. Wa	s an	24b. Were	autopsy fi	ndings available
vicion: The lay	page	Eo								per	opsy formed? 2 No	death	i? ∕es 2□ i	
	Tor, p	0	25. Was case referred to medical					26. Place	of Death	(Check only	\rightarrow			
_ S 00 3	director,	To B	examiner? Yes 2 □ No	Hospital: 1	Inpatient 2 🗆	ER/Outpatie	nt 3 DOA Othe	er: 4 🗆 Nur	sing Hon	ne 5 Re	sidence	6 Other (S	ipecify)	
ding Phy After this	nera		27. Manner of Death Natural 5 ☐ Pending	28a. Date (Mo	of Injury oth, Day Year)	28b. Time o	f 28c. Injun World	at c?	2	8d. Describe	how inju	iry occurred		
VISION Attending or death. rector: Afte	D	catl	2 ☐ Accident investiga	ition				Yes 2□N						
or Att	n by	ertification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	200. Flat	e of Injury - At he ding, etc. (Specif	ome, farm, st y)	reet, factory, office		2		(Street a. own, Stat	nd Number or e)	Rural Rou	ite Number,
pital ours an aral D	De .	O	20a Codifier	Obvoicies T ::	a boot of section	udod== d= :	h assured at the co	na data	t elec-	and dress to the	0.000-1) and more		
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After	completely filled in by the funeral	edical		xaminer: On the			h occurred at the tin estigation, in my of							
vithin o the	dwo	Me	29b. Signature and title of certifier				29c. License	number			29d. Da	ate signed (M	onth, Day,	Year)
- FF) NI L	1	(C)		D	480°	18		1	0 19	2006	0
· 2 m	3		30. Name and address of person w	no completed car	use of death (Item	n 23a) (Type	Print)			. :1./	1/2:0	V 10	165.	-in, Min
2111			D. YIJAY	KAR	J MBU	NATI	IAN 2	01 1	AL	L 1116	HWF	T/ CK	1211	21817
	Sta		31. Date filed (Month Cay: Year)	2006 32.	Registrar's Signa	iture	Carl .							
Re	gistr	ar	20	1	THE WALL	10. 14	103954.							

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of M	aryland /	Departme Certifica			nd Menta	l Hygiei Reg.	200	6	35082
	Physici		Decedent's Name (First, Middle, JoAnn	Laura	Rams	ey			2. Dat Mo			Year DD	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, COOSTAL HASA) 5. Social Security Number	ice at the	Lake		ity, Town, or Sults der 1 Year	Location of E	Death Hrs. 8. Dat	e of Birth	4c. County o	f Death	nico
d	Funeral Director		129-30-1120 Usual Residence of Decedent	. CT	74	Yrs. Mont	hs Days	Hours	Min. II	/24/19	31 I	Penn	lace (State or Foreign htry) Sylvania
	deeth with the Maryland me 23a or 28a-f show	ctor	10a. State 10b. County Maryland Wicon	nico		wn or Location						1	0d. Inside City Limits 1 XYes 2 No
	with the	I Directo	10e. Street and Number 1007 Riverside	Drive		1	Zip Code 21801			10g.	Citizen of WI USA	nat Cour	ntry?
36	or ite	by Funeral	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	If Yes, Give		i	cedent of H specify Cuba s 2 No	lispanic Origin in, Mexican, F Specify:	n? (Specify Ye Puerto Rican,	s or No- etc.)		, White,	
Maryland 21215-0036	within	Completed b	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Year or Dates: Education grade completed) College (1-4ors		a. Decedent's L (Give kind of life. DO NO Librar	work done of Tuse retired	ation during most of i)	f working	Wi	Kind of Bus	iness/Ind	dustry unty Board
land	e d in S	To Be C	17. Father's Name (First, Middle, L. Allen Myra	as t)					Name (First, Crude B)	
	end 2 should salth and Men n 27 le marke ier treumatic		19a. Informant's Name/Relationshir Katherine Jones		15	PO Box					y or Town, S	tate, Zip	Code)
Baltimore,	of H		20a. Method of Disposition 1 ☐ Burial 2 【 Cremation 3 4 ☐ Donation 5 ☐ Other (Sp.		cemet	of Disposition (tery, crematory of sbury C	or other plac		Date 0/20/06		Location - C		
Balt	permit. Pag Depertment Important: If eny Injury o	,	21. Signature of Funeral Service Li		C530	²² H01 501	16Way Snow	Funera Hill R	al Home Rd., Sa	Profe lisbur	ssiona y, MD	al A:	ssociation 04
	death certificate be executed e attanding physicien and d for use as the burial-transit	Ical Examiner	23a. Part1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions of any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Mete. Due to (br as b. Due to (or as	a consequence	. By e of): e ot):	node of dyin	1	rdiac or respir				Approximate Interval Between Onset and Death
O. Box 6	daath certifii e attanding p d for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 9 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant al 9 □ Unknown	2 Fetal dea	th 3 ⊟Ectopi 5 ☐ Other	c pregnancy (specify)				23d. Date Mont		ry Day Year
rds, P.	The law requires that tha di ite hes been signed by the page 2 should be detached	þ	Part II. Other significant condition	s contributing to death b	ut not resulting	in the underlyin	g cause give	en in Part I.	230	e. Did tobacc	\sim		e cause of death?
al Kecord	The lar ate hes page 2	Completed							_	a. Was an autopsy performed Yes	, de	ere autop or to cor ath? Yes	osy findings available inpletion of cause of
or Vital	Physician: this certific al director,	To Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) Yes 2 \(\text{No} \)	Hospital:		Outpatient 3	DOA Othe	00	Death (Checking Home 5[6 □Other	(Specify	<i>*</i>
DIVISION O	ling l	Certification:	27. Manner Death Natural 5 Pending investiga		y Year)	. Time of Injury M	28c. Injun Wor	yat <br Yes 2 □ No		scribe how in	ury occurred	t	
Š	Hospital or Attend 24 hours after death Funeral Director: tely filled in by the	Certifi	3 Suicide 6 Could no 4 Homicide determin	ed 286. Place of Inj building, et	c. (Specify)				City	or Town, St	ate)		l Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier 1 Certifying (Check only one)	Physician: To the best caminer: On the basis o and manner st	f examination a	ye, death conur and/or investigat	ed at the tim ion, in my op	ne, date and p pinion, death o	lace; and due occurred at the	to the nause e time, date a	(s) and man ind place, an	of as st d due to	ited. the cause(s)
	To the vithin 2 To the complet	Z	29b Signature and title of extition	04	mis	7	29c. License	number 262	78	29d. l	Date signed		* * * * * * * * * * * * * * * * * * * *
	La		30. Name and address of person w	ho completed cause of	eath (Item 23a	(Type, Print)			33	Solk	N	Da	180-
	Sta Registr		31. Date filed (Month, Day, Year) OCT 2	2006 32. Registr	ar's Signature	hast	,)		

Please Type or Print in Black Indelible Ink Zachary Daniel Robertson State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar

1 Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day October 26, 2006 Medical Examiner 1027 hrs ZACHARY DANIEL ROBERTSON 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death c. County of Death Washington Adventist Hospital Takoma Park Montgomery 5 Social Security Number If Under 1 Year If Under 24Hrs. 8 Date of Birth(MM/DD/YYYY) 9 Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) Country) Months Days Hours Director March 3, 1978 Maryland 1 X M 28 215-94-9020 Usual Residence of Decedent 10b County Inv 10a. State 10c City, Town or Location 10d Inside City Limits 1 X Yes 2 No 28a-f shov death with the Maryland Maryland Prince George's Hyattsville Director 10e. Street and Number 10f. Zip Code 10g Citizen of What Country è 3527 Madison Street 20782 U.S.A. 238 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc 1 X Never Married 2 Married 2 X No Yes 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: White Specify ð Dates: 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done 16b Kind of Business/Industry Completed during most of working life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages I and 2 should be filed within 77. Freath and Mental Hygiene trant: If item 27 is marked other than or other traumatic event, the Medical Baltimore, MD 21215-0036 Electrician Construction 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Mary Ellen Ervin <u>Joseph C. Robertson</u> 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ellen Young - Mother 12900 Clearfield Drive, Bowie, Maryland 20715 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date crematory or other place) 1 X Burial 2 Cremation 3 Removal from State permit Pages
Department of
Important: I 10/30/2006 Mount Olivet Cemetery Washington, DC Donation 5 Other Specify 22. Name and Address of Facility Signature of Funeral Service Licensee Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781 23a Part I. Enter the disease, or complications that caused the death? Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Complications of hencyclidina intoxication and oriate and cocaine use Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). and /sician/Medical physician a the burial -X UNPENDED X AMENDED 23a, g861, 11/17/06 TT Division of Vital Records, P.O. Box 68760, 23c. If ves. outcome of pregnancy 23d Date of delivery 3b Was decedent pregnant in the Ectopic pregnancy Fetal death Dav Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? this certificate ✓ Yes 2 No 1 V Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 / Inpatient 2 Other₄ ER/Outpatient 3 DOA Nursing Home 5 Residence 6 1 V Yes No After Manner of Death 28a Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred <u>...</u> Natural Pending 1 Yes 2 X No Director: Fnd 10/25/2006 Fnd 8:15 am unknown Certificat Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f Location (Street and Number or Rural Route Number, City or Town, State) 4303 Oglethorpe St. Hyattsville, MD 3 6 X Could not be Suicide within 24 hours a To the Funeral I determined (Specify) found in a residence Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical (Check only one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Carol Allan, MD Assistant Medical Examiner State Registrar

29b Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a)

111 Penn Street, Baltimore, MD 21201 Registrar's Signature

29c, License number

O.C.M.E.

29d Date signed (Month, Day, Year)

October 27, 2006

Thomas Shetton Baltimore, Maryland 21215-0036 Physic /Med Exam

Funera Director

permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or Items 23a or 28e-f show any highry or other treumatic event, the Medical Examinar must be notified at opnes. Physician /Medica Examine To the Hospitei or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physicien end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, 5A 2+1 Regis

	nt in Black Indelible Ink. Ensure Al	
State of M	aryland / Department of Health and M Certificate of Death	0000000001
1. Decedent's Name (First, Middle, Last)	Certificate of Death	2. Date of Death 3. Time of Death
Thomas Clayton Shol	ton	Oct. 19, 2006 9:05 P M
4a. Facility Name (If not institution, give street and number)		4c. County of Death
Salisbury Rehab+Nurs	ina Ctr. Salisbury	Wicomico
5. Social Security Numba 6. Sex 7. Ag	ge (ff-yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth 9. Birthplace (State or Foreign
578-09-1538	88 Yrs.	June 8, 1918 KY
10a. State 10b. County	10c. City, Town or Location	10d. Inside City Limits
MD Wicomico	Salisbury	1 X XYes 2 ☐ No
MD Wicomico 10e. Street and Number 5856 Cumberland Dr. 11. Marital Status 1 \(\text{Never Married} \) 2 \(\text{Married} \) Married 12. Was Decedent Armed Forces 1. Armed Forces 2.	10f. Zip Code	10g. Citizen of What Country?
5856 Cumberland Dr.	21804	USA Octiv Yes or No- 14. Race - American Indian.
11. Marital Status 12. Was Decedent Armed Forces 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Never Married 1 Never	If Yes, specify Cuban, Mexican, Puerto	
3XXWidowed 4 □ Divorced If Yes, Give Year or Dates:	1 Vec 2 No Consider	Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or	16a. Decedent's Usual Occupation (Give kind of work done during most of work)	16b. Kind of Business/Industry
Elementary/Secondary (0-12) College (1-4or	5+) life. DO NOT use retired)	
17. Father's Name (First, Middle, Last)	Watch maker	Jewelers (First, Middle, Maiden Surname)
17. Father's Name (First, Middle, Last) John K. Shelton		Lawrence
19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rura	
Wayne L. Shelton	5856 Cumberland Dr., S	Salisbury, Md. 21804
20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State
*4 □ Donation 5 □ Other (Specify)	Sunset Memorial Park 10-24	
21. Signature of Funeral Service Licensee	22. Name and Address of Facility The	Burbage Funeral Home
/ racqueline	Ustatu 108 William St., Be	
shock, or heart failure. List only one cause on each I	d the death. Of ot enter the mode of dying, such as cardiac one.	or respiratory arrest, Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	monk	days
Clim	nic obstructive pulmonery	diverse week
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a consequence of):	July 1
that initiated events		
	a consequence of):	
d		
IF FEMALE: 23c. If yes, outcome		23d. Date of delivery
in the past 12 months? 1 Yes 2 No 1 Yes 2 No	2 Fetal death 3 Ectopic pregnancy t time of death 5 Other (specify)	Month Day Year
9 Unknown		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death to	out not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
Parkinson's disease		1 Yes 2 No 3 Probably 4 Unknown
Dementia		24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of
		performed? death? 1 Yes 2 No 1 Yes 2 No
25. Was case referred to medical examiner?	Othor	(Check only one)
1 Inpati	ent 2 EH/Outpatient 3 DOA JUNISING Hor	me 5 Residence 6 Other (Specify) 28d. Describe how injury occurred
Natural 5 ☐ Pending (Month, Da 2 ☐ Accident investigation	ny Year) Injury Work? M 1 ☐ Yes 2 ☐ No	
3 Suicide 6 Could not be 28e. Place of In building, e	jury - At home, farm, street, factory, office (.C)pecify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	(Opooliy)	ony or rown, oraco)
29a. Certifier Certifying Physicien: To the best 2 Medical Exeminer: On the basis of	of my knowledge, death occurred at the time, date and place, a of examination and/or investigation, in my opinion, death occurre	and due to the cause(s) and manner as stated. ed at the time, date and place, and due to the cause(s)
29a. Certifier Certifying Physicien: To the best (Check only one) 2 Medical Exeminer: On the basis of and manner st	ated. 29c. License number	29d. Date signed (Month, Day, Year)
Los organizations of the state	77692	
30. Name and address of person who completed cause of	death (Item 23a) (Type Print)	10-2000
MINCrowley, Min 6/1	Dutchman's Lano Eas.	10.20.06 Ion, MD 21601
31. Date filed (Month, Day, Year) 32. Project	rar's Signature	
UCT 2 3 2006	ve & specie	

State of Maryland / Department of Health and Mental Hygiene 35085 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 4:30 A M 2006 Ralph Daniel Strople, Jr. October 19, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5832 Timberview Drive Elkridge Howard If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** XDM 2DF Director 012-32-8327 67 29, 1939 Massachusetts July Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location •how 10d. Inside City Limits Item 27 is marked other then "naturel", or Items 23s or 28s-f shov other treumatic event, the Madical Examinar must be notified at 1 Yes 2 No Maryland Howard Elkridge Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5832 Timberview Drive 21075 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. ified within 72 hours after of Hygiene.

Hygiene.

other then "naturel", or itel Affred Follows.

1 ⊠ Yes 2 □ No
If Yes, Give
Year or Dates: 1958-62 1 Never Married 2 Marned Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Computer Designer Computer Technology 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be finent of Health and Mental Hint: If Item 27 is marked of Ralph Daniel Strople Jessie Mae Bailey ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) A. Lois Gorenflo/friend 5832 Timberview Dr. Elkridge, MD 21075 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ة = 5 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Depertment of Important: If eny Injury or once. Chesapeake Crematory 10/21/06 Beltsville, MD 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784 21. Signature of Funeral Ser 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MD 21029 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Lyng (anciv /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed signed by the ettending physicien and I be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificete has the 1 Yes 2 No Hospital or Attending Physicien: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Injun 1 ☐ Yes 2 ☐ No death. 2 Accident investigation efter death 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide • Funeral f 1 Criffying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 1151811 octobe 19,200 is

State Registrar

31. Date filed (Month, Day, Year) OCT 23 2008

Thomas

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chioris



1120 N. Rolling Rd

Ba Hinn

MO 2/228

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 7:15 PM SICKLEI Melvin iD /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RENAISSANCE GARDENS - RIDERWOOD NURSING HOME MONTGOMERY SILVER SPRING If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 X M 2 ☐ F 274-36-8825 Director 90 NEW JERSEY APRIL 01, 1916 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No MARYLAND MONTGOMERY SILVER SPRING Direct 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 23a or 3112 GRACEFIELD ROAD #PV601 20904 U.S.A. death v 12. Was Decedent Ever in U.S. Armed Forces? "netural", or Iteme 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Peges 1 and 2 should be filed within 72 hours efter. Department of Health and Mental Hygiene. If Item 27 is marked other than "netural, or Itel any injury gother treumatic event, the Madical Examines once. Black, White, etc. 1 ☐ Yes 2 📆 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. þ 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ MINISTER 7TH DAY ADVENTIST CHURCH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be WALTER SICKLER ANNA TITUS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 BARN BRIDGE COURT, SILVER SPRING, MARYLAND 20904 JEANNIE CALLAN - DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) GEORGE WASHINGTON CEMETERY 10/20/2006 ADELPHI, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVENUE, SILVER SPRING, MARYLAND 20904 Musclin 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause if each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 107 /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner be executed attending physicien and I for use as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant The law requires that the death 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year signed by the at d be detached for 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 X No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2. No 2 🗀 No Division of Vital 1 ☐ Yes or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 🖽 o 1 Inpatient 2 ER/Outpatient P 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this ely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred Injury at Work? After 1 Natural 5 Pending investigation death. М 1 ☐ Yes 2 ☐ No after death 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and little & certifier 29c. License number 29d. Date signed (Month, Day, Year) 00043375 06 reson who completed cause of death (Item 23a) Type, Print) Karen W. Merritt Ceft Red Koad Silver Thing, Mis I 3110 Ducefield 31. Date filed (Month, Day, Year)
OCT 2 0 State Registrar

		1 - For State Registrar	State of M		d / Depa	artmer	nt of H					ZUUb	35087
Physi		Decedent's Name (First, Middle, Cecilia A. Segui							i	2. Date of Dea Month)ctober	Da	y Year • 2006	3. Time of Death 8:03a M
/Mec Exam		4a. Facility Name (If not institution,)		4b. City	, Town, or	Location of				. County of Deat	
		13038 Mill Hous				_	nanto					Montgome	
Funera Directo		5. Social Security Number 579-54-6472 Usual Residence of Decedent	. Sex 7. A 1 □ M 2 🔼 F	ge (In yrs. 86	last birthday) Yrs.	If Unde Months	Days	If Under 24 Hours	Min.	8. Date of Birt (Month, Pai)ct. 15	V, $Year$	920 Peri	hplace (State or Foreign untry) 1
BNG 21213-UU35 be filed within 72 hours after death with the Maryland ital Hygiene. ed other than "netural", or itema 23a or 28a-f ahow avant. It a Micklest Exercitar must be notified at	ctor	10a. State 10b. County Maryland Montgo	nery		y, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 🖺 No
with the a or 2	Dire	10e. Street and Number	a .				p Code		5			izen of What Co	•
eath na 23	eral	13038 Mill House	12. Was Deceden	t Ever in U	S 13		20874	isnanic Origi	in? (Snec	ify Yes or No		ted Stat	
036 urs after d Ni, or iten	by Funeral Directo	1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed Forces	:? ≵ No				n, Mexican, Specify:		cify Yes or No- lican, etc.)		Black, White	
Maryland 21215-0035 d 2 should be filed within 72 hours at th and Mental Hygiene. 27 is marked other than "natural; or traumatic avant. It a Medical Exert.	ted	15. Decedent's (Specify only highest	Education		16a. Dece	dent's Usu	ial Occupa	ation during most of	of workin	a l	16b. K	ind of Business/	Industry
LZ iffilio	Completed	Elementary/Secondary (0-12)	College (1-4o	5+)	life.	DO NOT	use retired)	Or WOIKIII	9		-	_
filed w Hygier Sthert	ပိ	12 17. Father's Name (First, Middle, La	net!			Coc	ok.	19 Mothod	'a Nama	(First, Middle,		assy of	Peru
and dibe to motal H	Be	Teodoro Seguil	(31)							Chuquil			
Ire, Maryland s 1 end 2 should be to if Health and Mental itam 27 is marked o	ဥ	19a. Informant's Name/Relationshi	(Type, Print)		19b. Maili	ng Addres	s (Street a					or Town, State, 2	Zip Code)
			(Daughter)		1	-					-	wn, MD 2	
Baltimore, permit. Pages 1 er Depertment of Hea important: if itam: any injury or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	☐Removal from State	9	Place of Disponentery, crei				Da			ncation - City or	
	ė	21. Signature of Funeral Service Li		I AI.	22	Name a	nd Addres	s of Facility	Del	ol Fun	era	I Home	TID
n garag		Volet H.	Dell-1		G) Eas	rsbu	er Par rg, MD	rk Di 208	rive 377			
Physiciar /Medica Examine	7	23a, Fart1. Eyfler the disease, or c sneek, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a. Gastric Due to (or a	line. Canc s a conseq	er uence of):	er the mo	de of dyin	g, such as ca	ardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death Months
68 / 6U, ifficate be executed g physicien and as the burial-transit	dical Examiner	ause. Enter Uncertying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or a										
the death certy the attending the attending to the attending to the attending the atte	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Feta	Ideath 3	Ectopic p	pregnancy	10 2				23d. Date of del Month	ivery Day Year
- 2° 5 8	þ	Part II. Other significant condition	s contributing to death	but not res	ulting in the u	nderlying	cause give	en in Part I.					the cause of death?
The The page	Completed		,							24a. Was autop perfor	sy med?	prior to death?	topsy findings available completion of cause of
T VITAL tysician: T tis certificet director, pa	Be (25. Was case referred to medical examiner?							of Death	(Check only o	ne)		
Phys this aldi	5	1 ☐ Yes 2 ☒ No 27. Manner of Death	Hospital: 1 Inpat		ER/Outpatier			4 🗀 14013				6 □Other (Spec	city)
DIVISION of or Attending lefter death. Director: After tin by the funer	Certification:	1 Natural 5 Pending 2 Accident investiga 3 Suicide 6 Could no	1	ay Year)	28b. Time o Injury	М	28c. Injun Work	rat c? Yes 2 □ No		8d. Describe h	iow injui	ry occurred	
DIVI		4 Homicide determin	ed 288. Place of II	etc. (Specif	(y) 					City or Tox	m, State	a)	ral Route Number,
To the Hospitel or within 24 hours efte To the Funeral Director Completely filled in It	Medical	(Check only 2 Medical E.	Physician: To the best taminer: On the basis and manner s	of examina	owledge, deat ation and/or in	n occurred vestigation	at the tim	ne, date and pinion, death	place, ar	nd due to the d d at the time, d	date and) and manner as d place, and due	stated. to the cause(s)
To tha I within 2 To the I complet	2	29b. Signature and title of certifier	2			29	c. License	number			29d. Da	te signed (Monti	n, Day, Year)
5		I White K	ejenjene				D424	52			0ct	ber 18,	2006
		30. Name and address of person w					n - D	****	27	01	MT	20022	
	tate	Chitra Rajagopal 31. Date filed (Month, Day, Year)	7					.ve #32	41,	Olney,	MD	20032	
- Regis		OCT 2 0	2006	ce L	ture do	and a							

		1-	For Stete Registrer		Sta	ite of I	Maryla				lealth a		ental Hy	giene	2006	3.5	088
		1.	Decedent's Name (Fir	st, Middle,	Last)								2. Date of Dea	ath			of Death
Phys /Me	ician dical		Virginia	Α.	Scude	ri							Month	22	17, 200	76 22	15 M
	niner	4a.	Facility Name (If not	institution,	give street	and numb	er)		4b. City	, Town, or	Location of	of Death			County of Dea		
		BX	Tooke Grove to	chairil	tation	and N	ursing	Center	S	andy	Spr	ing		J	Montg	onen	1
Funer	al		Social Security Number		. Sex 1 □ M 2		Age (in yes	. last birthday)	If Unde Months	r 1 Year Days	If Under	24 Hrs. Min.	8. Date of Birtl (Month, Day	h / Year)	9. Bi	rthplace (Sta	te or Foreign
Direct	or		77-32-702		I M 2			93 Yrs.					Feb. 11	, 1		hińgto	on, DC
pue *			ual Residence of Dec	edent c. County			10c. C	city. Town or Le	ocation							10d Inside	City Limits
Aaryl.	ō			24					~								es 212 No
the h	ec c	10	ryland	MOI	ntgome	ery		Sand	y Spr	p Code				10a Cit	izen of What C		
with a s	ㅁ	1	.8201 Slade	e Sch	001 R	her.			101. 21		0860			rog. Cit	USA	ountry :	
eeth Tare	era	11	Marital Status	e bene			nt Ever in	U.S. 13	Was Dece			nin? (Sne	city Yes or No-		14. Race - Am	erican Indian	
1215-0036 within 72 hours after deeth with the Maryland ene. then "natural", or items 23a or 28a-1 show the Madical Examinar must be notified at	by Funeral Directo		1 Never Married 3 2 Widowed 4		d 1 [med Force Yes 2 'es, Give ar or Date	es? ☑XNo		If Yes, spo 1 Yes		n, Mexican Specify:	, Puerto F	city Yes or No- Rican, etc.)		Black, Wh Specify: Wh	ite, etc.	•
21215-0036 solution 72 hours aff giene. or then "natural", or it the Medical Exerti	l ba	-		Decedent's				16a. Dece	dent's Usi	ial Occupa	ation			16h K	ind of Busines	s/lodustov	
15 in 72 and 16	Completed		(Specify or	nly highest	grade comp			(Give	kind of w		durina most	t of workir	ng	100.10	ing or busines.	waldustry	
Z die eigen	E	'	Elementary/Secondary	y (0-12)	Co	llege (1-4	or 5+)	Sec	retar	v			!	Un:	ited St	ates Go	vernment
Strange Tille	BeC	17.	Father's Name (First	, Middle, La	ist)						18. Mothe	r's Name	(First, Middle,	Maiden	Sumame)		
/lar uld be Wenta urked	년 B		John Carro	oll Al	nearn						Fel	issa	Davis				
Maryland and 2 should be file alth and Mental Hy 27 Is merked oth r traumatic event		19	a. Informant's Name/I Tames K. Al										Route Numbe				
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Deportment of Health and Mantal Hygione. Importent: If time 27 is marked other then "natural; or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar must be retained at		20:	a. Method of Dispositi 1 ☑ Burial 2 ☐ Cre 4 ☐ Donation 5 ☐	emation 3		al from Sta	ite	Place of Dispo cemetery, create ate of He	matory or	other place	10	ctobe			ocation - City o		
THE STATE OF THE PERSON AND PERSO	ė	21	. Signature of Funeral	Service Li	ensee		1 00					2000	o Funeral		ver Srr	ing, Ma	ryland
P S S E	8		Mill	EB	med	1		5	00 Un	iver:	sity	Blvd	., W.,	Sil	me inc. Ver Spr	ing, M	ID 20901
		23	la. Part1. Enter the dis	sease, or co ure. List or	mplication by one cau	s that cau	sed the dea	ith. Do not en	ter the mo	de of dying	g, such as	cardiac o	r respiratory arr	rest,		Approxin	nate Between
Physicia	n		mediate Cause (Final	I		Wn	CAR	DIAL	12	FAF	ZCT	100	1			MIN	
/Medic		re	sulting in death)	4	_			quence of):		-						1-(1)-	0 10 3
Examine		Se	quentially list condition	ns	b												
ם כ	Examiner	n a	iny, leading to immeduse. Enter Underlying use (Disease or injury	late 1		ue to (or	as a conse	quenca of).									
acute and trans	am	tha	use (Disease or injur) it initiated events sulting in death) Last	'	C.												
50, se exe	Ä	10:	suiting in deatily cast		1	Due to (or	as a conse	quence of):									
\$8760, icate be executed physicien end s the burial-transit	dica				d												
X 6 entific	Ğ.	IF	FEMALE:		02- 4-									I			
Box eath certi ettending for use a	la Z	23	 b. Was decedent preg in the past 12 month 		10	Live birth	me of pregr	al death 3	Ectopic p						23d. Date of de Month	Day	Year
P.O. BOX 6: thet the death certific ed by the ettending p detached for use as	Physician/Medical		1 ☐ Yes 2 No 9 ☐ Unknown			Unknow	t at time of	death 5L	Other (s	pecify)						,	
Thet bed by deta	by Pr	Pa	t II. Other significant	condition	s contributi	ng to deat	h but not re	sulting in the u	nderlying	cause give	en in Part I.		23e. Did to	bacco u	ise contribute i	o the cause of	of death?
Division of Vital Records, P.O. Box 68760, in or Attending Physicien: The law requires that the death certificate be executed after death. Director: After this certificate has been signed by the ettending physicien end in by the funeral director, page 2 should be detached for use as the burial-transit	ed b	_	VASCUL	AR I	EM	EN	TA						1 🗆 Y	es 2	Z No 3□P	robably 4	∐Unknown
aw re	Completed												24a. Was a		24b. Were a	utopsy findin	s available
Re lay	E												autops perfor		death?		t cause of
ita itari	a) a)	25	Was case referred to	medical	1						26. Place	of Death	Check only or		1010	2 2 140	
f <	To B		examiner? 1 ☐ Yes 2 📉 No		Hospita	l: 1 🔲 Inpa	atient 2	☐ ER/Outpatier	nt 3 D	OA Othe			ne 5 🗆 Resid		6 □Other (Spe	ecify)	
O P P P P P P P P P P P P P P P P P P P	=	27.	Manner of Death	7.D	28a	. Date of I	njury Day Year)	28b. Time o	f	28c. Injury Work		- 1	8d. Describe h				
ondin ath.	atic		1 Accident 5 [☐ Pending investiga	tion	(July 1, 54.7	11,101,7	М		res 2 🗆 1	No					
Or Atter de Directe in by the	Certification:		3 ☐ Suicide 6 [4 ☐ Homicide	Could no determin		. Place of building,	Injury - At I	home, farm, str	reet, factor	y, office		2	8f. Location (S. City or Town			lural Route N	umber,
Dital o																	
Division of Vital Re To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director; After this certificate he completely filled in by the funeral director, page	edical	29	a. Certifier 12 (Chack only 2 one)	Certifying Medical Ex	aminer. O	To the be n the base d manner	s of examin	nowledge, deat nation and/or in	h occurred vestigation	at the tim	ie, date and pinion, deat	d place, a th occurre	nd due to the c d at the time, d	ause(s) late and	and manner a place, and du	s stated. e to the caus	e(s)
To th Withir To th	×		b. Signature and title	of certifier					29	c. License					e signed (Mon		
			> yrn	~M) ST	AFF	PHY	SICIAN		DI	120	46	(CI	OBERI	8,20	006
3		30.	Name and address of	of person wh		_	-			_		. 0		_			01.6
	State	G 31	ace Brook Date filed (Month, Da	ay, Year)	fnon	n, M.∽ 3 Reg	D . 19	ature _	slad	e 5	cho	ol Ko	od San	45	ober l	larylar	d
Regi			OCT	202	2006	Bow	w L	nature	W.								

Baltimore, Maryland 21215-0036

Box 68760.

o

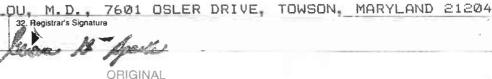
Division of Vital Records. P.

State Registrar

NOV 0 3 2006

ABDALLAH J.

31. Date filed (Month, Day, Year)



D17695

October 29,2006

lou, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

		For State Registrar	State of Marylar	•	artment of H			ene 9. N2 0 0 6	35090
Physic /Med	44	Decedent's Name (First, Middle, Last) Lillian Helen	Umstead				2. Date of Death Month October	Day 2 ^{Year} 200	3. Time of Death 11:15A M
Exami	ner	4a. Facility Name (If not institution, give st Carroll Hospital Co 5. Social Security Number 6. Sex		last hirthday)		inster		4c. County of Dea	
Funeral Director			M 20 X F 77	Yrs.	Months Days	Hours Min.		, 1929 M	ary land
the Maryland 28e-1 ehow	rector	10a. State 10b. County Maryland Carroll 10e. Street and Number	10c. C	ity, Town or Lo	New Winds	or	10	g. Citizen of What C	10d. Inside City Limits 1X Yes 2 □ No
and 21215-0036 be filed within 72 hours after death with the Maryland tial Hygiene. In other then "natural", or iteme 23a or 28e-1 show event, the Madical Examinar must be notified at	by Funeral Director	2831 Carlisle Dr 11. Marital Status 1 Never Married 2 Marned 3 Widowed 4 Divorced	2. Was Decedent Ever in UAmed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🗷 No		Specify Yes or No- to Rican, etc.)	U.S.A 14. Race - Am Black, Wh Specify:	erican Indian,
Maryland 21215-0036 nd 2 should be filed within 72 hours att tilh and Mental Hylgiene. 27 ie marked other then "natural; or resumatic event, the Madical Exert	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12) 12		(Give	dent's Usual Occup kind of work done o DO NOT use retired omemaker	during most of wo	rking	6b. Kind of Busines:	s/Industry
aryland should be file and Mental Hy marked oth umatic event	To Be	17. Father's Name (First, Middle, Last) Walter Winters				He l	me (First, Middle, M en Turner		
Baltimore, Maryls permit. Pages 1 and 2 should Department of Health and Mer Important: if item 27 is marks any nijury or other traumatic once.		19a. Informant's Name/Relationship (Typ Richard F. Umstead 20a. Method of Disposition 1 Burial 2 Stermation 3 Re 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	/ husband 20b. A1	2831 Place of Disponentery, cre 1 Coun	Carlisle position (Name of matory or other place ty Cremat	Dr. N ion 10/2 ss of Facility Ha	ew Windso Date 2 3/2006 S rtzler Fu ew Windso	r, MD 217 Oc. Location - City o ykesville neral Hom	76 or Town, State , MD
.O. Box 68760, the death certificate be executed Wedgrea Whe attending physicien and the attending physicien and the burial-transit	dicai Examiner	23a. Part.1 Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con-	quence of):		g, such as cardia Ouluu Faul	2	st,	Approximate Interval Between Onset and Death Death Onset and D
O.O. Box 6. It the death certific by the attending p tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ♠No 9 ☐ Unknown	ic. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of do Month	elivery Day Year
rds, P. quires that an signed by	þ	Part II. Other significant conditions conf	ributing to death but not re	sulting in the u	ınderiying cause giv	en in Part I.	23e. Did toba		to the cause of death? Probably 4 Unknown
al Records, P The law requires that cate has been signed b	Completed						24a. Was an autopsy perform	ed? prior to	autopsy findings available ocompletion of cause of ss 2 \(\text{No} \)
Division of Vital n or Attending Physicien: T atter death. Director: After this certificat d in by the funeral director, pa	Certification: To Be	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Injur Wor M 1 🗆	er: 4 \(\text{ Nursing I}\)		nce 6 Other (Sp w injury occurred	ecify) Gural Route Number,
P Stigie		29a. Certifier 1 Certifying Phys	building, etc. (Specifician: To the best of my know; On the basis of examination)	nowledge, dea	th occurred at the tir	ne, date and place	e, and due to the ca	use(s) and manner	as stated.
To the Hospital within 24 hours a To the Funeral L complately filled	Medical	29b. Signature and title of certifies	and manner stated.		200 Linns	o oumbor		d Data signed (Mar	ath Day Year
3	tate		mpleted cause of death (Ite RE 151 32. Registrar's Sign	295 S 295 S nature	Print)	Au	vistam	ster HS	21157
Regis	trar	OCT 2 3 2	32. Registrar's Sign	K	Angel.				

State of Maryland / Department of Health and Mental Hygiene 006 1 - For State Registrar Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death **Physician** 17, 1006 October 12:45 P M Whittington Margaret Agnes /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel South River Health & Rehabilitation Edgewater If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Jan. 26, 1920 Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛣 F Months Days Yrs. 217-58-4589 86 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County Item 27 is marked other than "neturel", or Items 23s or 28s-1 show other traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2√ No MD Deale Anne Arundel Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20751 U.S.A. 6173 Owings Beach Road Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White δ 3 N Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) el Hygiene. Elementary/Secondary (0-12) 12. College (1-4or 5+) librarian county library 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be marked o Pages 1 and 2 should be Palmer Atwell Agnes James Marcellus Jovce 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 613 Deale Road, Deale, MD 20751 if Health if Terry D. Whittington, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 10-20-2006 Lothian, MD St. James Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fugeral Service Licensee 22. Name and Address of Facility any in Rausch Funeral Home, PA Owings, MD 20736 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** HOUR /Medical Due to for as a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine attending physicien and for use as the burial-transit The law requires that the deat certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day 4 ☐ Pregnant at time of death signed by the at the detached for 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has the irector, page 2 s 1 Yes or Attending Physician: director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) After thi funeral 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Tes 2 No deeth. Director: / 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after of To the Funeral Directompletely filled in by determined 4 Homicide Fo the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and little of certifier 105158 Tarven 30. Name and address of prison with completed cause of math (Item 23a) (Type, Print) INFEL SHALL SILE 32. Registras Signature 31. Date filed (Month, Day, Year) State OCT 2 0 2006 Magne . Registrar

			1 - For State Registrar	State of Ma	ryland	-	rtment of tificate of		nd Mental	Hygien	211116	35092
			1. Decedent's Name (First, Middle, L.	ast)					2. Date Mont	of Death	ay Year	3. Time of Death
	Physicia /Medic		JACK	WILLARD	WARD)				cher	28 20	
	Examin		4a. Facility Name (If not institution, gr	ve street and number)			4b. City, Town,	or Location of			c. County of Dea	ath
			Peninsula legi	onal medic	al 6	enter	Sa	lisbur	4		Wicon	nia
	Funeral			1014 005	(In yrs. las		If Under 1 Yea Months Day:		Min. (Mont	th, Day, Yea	r) C	rthplace (State or Foreign Country)
	Director		225-14-3145	X 2 8	5	Yrs.			Ju1y	6,192	l Vir	ginia
, pue	*		Usual Residence of Decedent 10a. State 10b. County		10c. City, 1	Town or Loc	cation					10d. Inside City Limits
2	e 9	ō										1 X Yes 2 □ No
the	or 28e-f show e notified at	Director	Maryland Wicomico 10e. Street and Number		Salis	bury	10f. Zip Code			10a. C	itizen of What C	Country?
3	el, or iteme 23a or 28e-f shou Exercitat must be rediffed at		1516 Woodland Roa	d			21801			US		,
feeth	ne 2	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S.	13. V		Hispanic Origi	in? (Specify Yes Puerto Rican, et		14. Race - Am	
, in the	riteme	Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 277 N	ю				Puerto Rican, et	c.)	Black, Wh	
3	- 1	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		'	☐ Yes 2 X N	o Specity:			Specify: Wh	ite
d E 1 E 1 S-0000 filed within 72 hours after death with the Maryland	"naturel", or	Completed	15. Decedent's E (Specify only highest g	ducation ade completed)		16a. Deced	ent's Usual Occ kind of work don	upation e during most o	of working		Kind of Busines	•
1 ig	9 6	du	Elementary/Secondary (0-12)	College (1-4or 5-	+)	life. L	OO NOT use retii	red)			aper Con	munications
1 8	ygier it, in			2	1	oroade	casting/	1	resident		- 0	
2 2	d oth	Be	17. Father's Name (First, Middle, Las	t)					s Name (First, M na Hopki		in Sumame)	
Should be	is marked other them and Mental Hygiene.	ဥ	Willard M. Ward	CT 0 (1)		405 14 11	(0)				T	7: 0-11
-	h and		19a. Informant's Name/Relationship Bernetta Evans Wa				•		or Rural Route I			Zip Code)
1 200	・エミコ		20a. Method of Disposition	ild- wile			sition (Name of natory or other p		Date		Location - City o	r Town, State
5	or or or		1 X Burial 2 Cremation 3		I.				ov.5,200		rionvil]	
	Depertment Importent: I efiy injury o		4 ☐ Donation 5 ☐ Other (Spec 21. Signatur of Funeral Service Lice		Red		Cemeter Name and Add	-	_		P.O. Box	
	Depe impo eńy i		21. Signatury of Puriod Solving Lice	7.77					Home, I			VA 23350
			23a. Part1. Enter the disease, or cor	nplications that caused	the death.						ixiio.c,	Approximate
			shock, or heart failure. List only Immediate Cause (Final	one cause on each lin	G	·	4;					Interval Between Onset and Death
	hysician /Medical		disease or condition resulting in death)	a. Pile	140	Ten	(1)7			1000		2 days
	xaminer			MO (71.9	40+	C OI).	calen	CCM	Cer			1012 Aces
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	conseque	nce of):	20101	(-				60073
Ta ta	and and and and and and and and and and	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Colon	C	cer ce						(0415 -
to be executed	an an	Exa	resulting in death) Last	Due to (or as a	consequer	nce of):						
5 4	been signed by the attending physicien and should be detached for use as the burial-transit	cal	•	d								
	ng ph	Jed	IF FEMALE:									
5 5	ruse	an/h	23b. Was decedent pregnant	23c. If yes, outcome of 1 Live birth			Ectopic pregnan	ncv			23d. Date of de	•
	he at ed fo	SICI	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at t 9☐Unknown	time of deat		Other (specify)				Month	Day Year
ا ا	1 by t	Physician/Med	9 Unknown					1. D. 41	222	Did tabassa		to the course of death?
<u>ה</u> פֿ	bed bed	δ	Part II. Other significant conditions	contributing to death bu	It not resulti	ng in the ur	ideriying cause (given in Part I.	230.			to the cause of death?
5	e nee	ted	I ((0 <	W F	ane	20 70	30-(_	1 Yes	2 2 √√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√	Probably 4 Unknown
ב ע	les b	Completed							24a.	Was an autopsy	prior to	autopsy findings available completion of cause of
<u> </u>	page	Con							10	performed? Yes 2 1	death?	
	After this certificete hes funeral director, page 2	Be	25. Was case referred to medical examiner?						of Death (Check	only one)		
	this diff	은	1 ☐ Yes 2 ☑ No	Hospital: 1 Impatier		VOutpatien	3 DOA		sing Home 5			ecify)
	After	i o	27. Manner of Death 1 ■ Natural 5 □ Pending	28a. Date of Injur (Month, Day	Year) 2	Bb. Time of Injury	28c. In			cribe how in	ury occurred	
מילים	tor: /	cat	2 Accident investigati 3 Suicide 6 Could not	he -	A1 h a sa	- 4		□Yes 2□N		tion /Ctrant	and Alumbar or I	Sure I Down Atomber
	ofter of in by	Certification;	4 Homicide determine	28e. Place of Inju building, etc	. (Specify)	e, τarm, stre	eet, factory, offic	е		or Town, Sta		Rural Route Number,
UIVISIOSI OI VIIGI NECOLOS, F.O. DOX 06	within 24 hours effect death. To the Funerel Director: A completely filled in by the fu		29a. Certifier 1 Certifying F	hysician: To the best of	of my knowle	edge death	occurred at the	time date and	place, and due t	to the cause	s) and manner	as stated
1	Fun etely	Medical	(Check only 2 Medical Expone)	miner: On the basis of and manner sta	examination	n and/or inv	restigation, in my	opinion, death	occurred at the	time, date a	nd place, and du	ue to the cause(s)
	o thin	₹	29b. Agria ure and title of cerufier	-		~		nse number		- 1	ate signed (Mor	**
	7 (- 0		10 2 4 100	ULEMA	M	0	D4	4688		1	2-28	-2006
	11		30. Name and address if person who	condited cause of de	eath (Item 2	フ 3a) (Type, l	Print)	_ ^ ^	1		0	2 .0 - 1
	1 *		560 Riversid	e In s	rute	A:	204,	Sa (1)	bury	10	UP.	-2006 21801
	Sta Registr		31. Date filed (Month, Day, Year)	degistra	r's Signatur	8	B. 0					

			1 - For State Registrar	State of N	/laryland		artment rtificate			ind Me		giena Reg. No.	006	350	93
r	Physici	an	Decedent's Name (First, Middle Decedent's Name (First, Middle)	, Last)	١٨/	easent	forth				2. Date of De Month	Day	Year	3. Time of	Death
V	/Medic	2	Donald 4a. Facility Name (If not institution,	give street and numbe		easem		Town, or	Location o	f Death	10-		ounty of Dea	O I I I	/ 1)
	CXAIIII	Ç.	18617 McMuller	Highway			Raw	lings	3			Alle	egany		
	Funeral Director		5. Social Security Number 216-22-5895 Usual Residence of Decedent	6. Sex 7. / 1 M 2 □ F	Age (In yrs. Ia 83	ast birthday) Yrs.	ff Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Pa NOV	th 5, 192	C	rthplace (State of ountry)	or Foreign
	72 hours after death with the Maryland natures; or Items 23s or 28s-4 show dical Examinar must be notified at	_	10a. State 10b. County MD Allec	ianv	10c. City	, Town or Lo								10d. Inside C	•
	28a-f	ecto	10e. Street and Number	, arry		- COVIII	10f. Zip	Code				10n Citize	n of What C	1 Yes	*
	3a or	i Dir	18617 McMuller	n Highway			101. 2.0		21557	•			USA		
	r deat	Funeral Director	11. Marital Status	12. Was Deceder Armed Force	s?	5. 13.	Was Deced	as Decedent of Hispanic Origin? (Specify Yes or Yes, specify Cuban, Mexican, Puerto Rican, etc.			cify Yes or No)- 14	. Race - Am Black, Whi	erican Indian, ite, etc.	
36	irs afte	by Fu	1 ☐ Never Married 2 ☐ Marri 3 ☐ Worldowed 4 ☐ Divorced	ed 1 Tes 2 If Yes, Give Year or Dates	€ _{No}		1 ☐ Yes 2	No 🏝	Specify:			Si	pecify: wh	ite	
2-00	72 hou nature	eted	15. Decedent (Specify only highes	's Education		16a. Dece	dent's Usual kind of won	l Occupa	ition	of workin	a	16b. Kind	6b. Kind of Business/Industry		
121	within lene. than "	Completed	Elementary/Secondary (0-12)	Cotlege (1-4o	r 5+)	Fork L	DO NOT us	e retired,	}		9	Tiro (o Company		
d 2	es 1 and 2 should be filed of Health and Mental Hygi filsm 27 is marked other r other traumatic svent, I	0	12 17. Father's Name (First, Middle, I	Last)		IOIKL	пі Оре	siall		r's Name	Tire Company me (First, Middle, Maiden Sumame)				
Maryland 21215-0036		To B	Charles Ervin		th						(Liller)				
			19a. Informant's Name/Relationsh Deborah Davis		ghter	19b. Mailii 141	ng Address 5 Com	(Street a	nd Numbe ce Sti	r or Rural reet	Winc	er, City or T hester	own, State,	VA 22	601
Baltimore,			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp			ace of Dispo metery, crei tlawn M					1/1/2006	20c. Loca		Town, State	MD
Balt	permit. Pag Department Important: I sny injury o		21. Signatur of Juneral Service I	icensee M	11.	22					me, P.A. Cumber		AD 2150	1 2	
IMedical resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of):							yar c	of dying	, such as	cardiac or	respiratory a	rrest,		Approximat Interval Bet Onset and I	ween Death
8760,	icate be executed physician and the burial-transit	icai Exa	that initiated events resulting in death) Last	c. Due to (or a	as a consequ	ence of):									
9	tificating phy as the	ledic		- U.											
P.O. Box	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the buriat-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 ☐ Fetal at time of de	death 3[Ectopic pre					230	d. Date of de Month	,	fear
	w requires that been signed b should be deta		Parkinsons d		but not resu HTN		nderlying ca abet		n in Part I.		23e. Did t			o the cause of c	
i Records,	The law requirate has been page 2 should	Completed by									24a. Was autor perfo	osy ormed?	24b. Were a prior to death?	utopsy findings completion of c	available ause of
Vital	ding Physician: Th n. After this certificate funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			500	! Otho		of Death	Check only o	one)			
of		: To	1 ☐ Yes 2√Z0No 27. Manner of Death	28a. Date of Ir (Month, L	itient 2 🗆 E	ER/Outpatier 28b. Time o			4 140		e 5/20Resi			ecify)	
ion	Attending F death. ctor: After y the funer	atior	1 SNatural 5 ☐ Pending 2 ☐ Accident investig	9	Day Year)	Injury	М	3c. Injury Work 1 🔲 Y	? ′es 2 ☐ N			,,			
Division	al or Atte after des i Directo d in by th	Certification:	3 Suicide 6 Could r 4 Homicide determi	ned 286. Place of	Injury - At hore etc. (Specify)	me, farm, sti	reet, factory,	office		2	Bf. Location (: City or To	Street and I wn, State)	Vu <i>mb</i> er or R	lural Route Num	ber,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	Medicai C	29a. Certifier (Check only one) Certifyin 2 Medical I	g Physician: To the be Examiner: On the basis and manner	of examinati	vledge, deat ion and/or in	h occurred a vestigation,	at the tim	e, date and inion, deat	d place, a	nd due to the d at the time,	cause(s) ar date and pl	nd manner a lace, and du	s stated. e to the cause(s)
	To the within To the comp	M	29b. Signature and title of certifier Hma Su	and MD				License	number	ila		4	signed (Mon	th, Dey, Year)	
-	(0		30. Name and address of person	who completed cause o	f death (ftem	23a) (Type,		U_7	- 0	Ψ					
	*		Huma Shakil 1 31. Date filed (Month, Day, Year).	M.D.	strar's Cionat	625 k	Kent A	venu	ie Sui	ite 30	4 Cum	berlar	nd MD	21502	
13	Sta Regist			2006	strar's Signat	R 1	house !	,							
DH	MH 17 Rev 1/2	001	INDA A C	1.000		ar fil									

ORIGINAL

	•		1 - For State Registrar	State of Maryl			of Health and of Death		gierfe UUD leg. No.	33034	
3	Dhyaisi	35	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	th Day Yeer	3. Time of Death	
	Physici /Medic		JOHN TIMOTHY W				OCTOBE		6 12:44P M		
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Tov	vn, or Location of Dea	th	4c. County of De	ath	
	20 4	.4	2908 STAVORS RO				LDORF		CHARLES		
14	Funeral Director		5. Social Security Number 6. Sec. XI	VM 2FF	yrs. last birthday) 33 Yrs.	If Under 1 Y Months D		. (Month, Day	of Birth h, Day, Year) 9. Birthplace (State of Country) WASH., DC		
115.00			Usual Residence of Decedent		3			MAR. 16	, 1953 WA	SH, DC	
	yland		10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits	
	a-fa	ctor	MARYLAND CHAR	LES	WALDOR	F				1 ☐ Yes 2X No	
	or 28	Director	10e. Street and Number			10f. Zip Co	de	1	log. Citizen of What (Country?	
	(f) wi		2908 STAVORS RO	AD		20	0603		U.S	.A.	
	sep .	Funeral	11. Marital Status	12. Was Decedent Ever i Armed Forces?	n U.S. 13.	Was Decedent	of Hispanic Origin? (Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - An Black, Wh		
36	72 hours after death with the Maryland naturel; or Items 23a or 28a-f show disal Examiner must be notilied at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2X No If Yes, Give Year or Dates:	-	1 □ Yes 2 🖸			Specify: W		
21215-0036	72 hour	ed t	15. Decedent's Edu		16a, Dece	dent's Usual O	ccupation		16b. Kind of Busines	s/Industry	
215	within 72 ene. than "na	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of work d DO NOT use re	one during most of we etired)	orking	Top. Time of Business	amaasiy	
217	d with	E	12	4	CI	TY MAI	L CARRIE	lR	U.S.POST	AL SERVICE	
	be filed tal Hygi d other event, t	Bec	17. Father's Name (First, Middle, Last)					me (First, Middle, i			
Maryland		၉	WILLIAM GRIER						N TRANME		
Mar	C1 00 - 00		19a. Informant's Name/Relationship (Ty) KRISTEN S. WHIT	•					r, City or Town, State,		
	of Healt of Healt if Item 2 or other		20a. Method of Disposition		b. Place of Dispo			- the same of the	, MD 206 20c. Location - City of		
ğ			1 ☐ Burial 21 Cremation 3 ☐ R	lemoval from State	cemetery, crei	natory or other	place)				
Baltimore,		1	4 □Donation 5 □ Other (Specify) 21. Signature of Fugeral Service License		MO0479		TORY 10 –	24-06	ALEXANDR	IA, VA	
å	permit. Departr Importa		12 Much			RAYMO	OND FUNER	AL SERV	ICE, P.A	•	
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the d	leath. Do not ent	er the mode of	dying, such as cona	c or respiratory arr	0646 est,	Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	Sandal	11 /11	2-4-6	Library	un C.	a claus	Onset and Death	
	/Medical		resulting in death)	Due to (or as a con	sequence of)	1000	1.000			Fylor	
	Examiner		Sequentially list conditions	Morros	50.0	1365I	TY			- mus	
_	ם ש	ner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con	sacuence of)			1		9	
13	and trans	Examin	that initiated events resulting in death) Last	ATRI	140.42	33 K3	ZGBA TO	<i>((((((((((</i>			
68760;	ficate be executed physicien and s the burial-transit			Due to (or as a con	sequence oi):						
587	phy:	edical		1							
_		/We	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pre	gnancy				23d. Date of de	alnen	
Вох	death a atter	clar	in the past 12 months?	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time		Ectopic pregn Other (specif			Month	Day Year	
O.	at the de by the a	Physician/M	9 Unknown	9□ Unknown							
s, P	law requires that the death cert as been signed by the attending 2 should be detached for use a	by P	Part II. Other significant conditions con	ntributing to death but not	resulting in the u	nderlying cause	given in Part I.	23e. Did tot	bacco use contribute	to the cause of death?	
of Vital Records,	w require been sig should b							1 🗆 Ye	es 200 00 3 □ F	Probably 4 Unknown	
ec	taw re las be	Completed						24a. Was a autops		utopsy findings available completion of cause of	
<u>ж</u>	The ate h page	NO.						perform	ned? death?		
/ita	Physician: This certificateral director, p	Be (25. Was case referred to medical examiner?			107-177-	26. Place of De	ath Check only on			
£	Physi this o	ို	1 □ Yes 2 No		2 ER/Outpatier		Other: 4 Nursing	Home 5 Reside	ence 6 Other (Sp.	ecify)	
	ding P	on:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	r) 28b. Time of Injury		Injury at Work?	28d. Describe ho	ow injury occurred		
isic	Attending in death. ctor: After by the fune	Icat	2 Accident investigation 3 Suicide 6 Could not be	20a Place of Injury	At home form -t-	M	1 ☐ Yes 2 ☐ No	20f Leasting (Ct	100 - 4	North Courts At anh	
Division	after death Director: I in by the	Certification:	4 Homicide determined	28e. Place of Injury - A building, etc. (Sp	ecify)	eet, ractory, on	IIC 0	City or Town	reet and Number or F n, State)	sural Houte Number,	
	Hospitat 24 hours a Funeral D etely filled i	a C	29a. Certifier 1 Certifying Phys	ician: To the best of my	knowledge, deat	occurred at th	ne time, date and plac	e, and due to the ca	ause(s) and manner a	is stated.	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Attercompletely filled in by the funer	edical	(Check only 2 Medical Examir one)	ner: On the basis of exam and manner stated.	nination and/or in	estigation, in r	ny opinion, death occ	urred at the time, da	ate and place, and du	e to the cause(s)	
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	1	1	29c. Lic	cense number	70 2	9d. Date signed (Mon	th, Pay, Year)	
			1 Just	HON) Lr	V7)	DIO	004	10/20	106	
	12		30. Name and address of person who do	mpleted cause of death (Item 23a) (Type,	Print	WALNO	MY- W	nd 20	103	
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Si	ignature		V V II V D	, ,		6.	
18.	Registr		NOV 0 2 2006	124	to do	180					

		•	For State Ragistrar		State of	f Maryl	and / De	partme	ent of H	lealth a					3509	5
	Physicia		Decedent's Name (First, DONALD STEVE									2. Date of Do Month		y Year	3. Time of Dea 6 6:10 AM	
	/Medic Examin		4a. Facility Name (If not inst 322 ALLEGANY	titution, give	street and nu	mber)			ty, Town, or			OUL	4c	County of Dea	ith	.1
	Funeral Director		5. Social Security Number 219-46-0092	6. Se 1∑		7. Age (In y 59	rs. last birtho	ay) If Un	der 1 Year		Min.	B. Date of Bi (Month, D	rth ay, Year)			
	Marylend 1 show	or	Usual Residence of Decederation 10a. State 10b. C				City, Town o								10d. Inside City Lin	
	with the 3a or 28e-	Funeral Director	10e. Street and Number 322 ALLEGANY	STREE	err				Zip Code	-			_	tizen of What C		
036	within 72 hours after death with the Marylend ene. Than "natural", or Items 23a or 28e-f show the Madical Exeminer must be notilled at	by	11. Marital Status 1 Never Married 2 3 Widowed 4 Div] Married	12. Was Dec Armed Fo 1 Tyes If Yes, Gi Year or D	orces? 2 📉 No ve	n U.S.	3. Was De		ispanic Ori n, Mexican Specify:	gin? (Spec , Puerto R	ify Yes or Nican, etc.)		14. Race - Am Black, Whi	erican Indian, te, etc.	
21215-0036	2 should be filed within 72 hours after death with the Marylen and Mental Hygiene and Mental Hygiene is marked other than "natural", or items 23a or 28e-f show eumatic event, the Madical Examiner must be notified at	Completed	15. De (Specify only Elementary/Secondary (0	10)	cation e completed) College (- (G	ive kind of e. DO NO	sual Occup work done of use retired AGENT	during mosi d)	t of working	9		ind of Business	/Industry	
ō	uld be filed Mental Hygid arked other atic event, il	To Be C	17. Father's Name (First, M WILLIAM P. V									(First, Middle BARNE				
, Mar	and 2 sho ealth and m 27 is m						1910	8 OLI	DANS		ROAL	FROS	TBUR		1532	
altimore,	permit. Pages 1 and 2 should be Depertment of Health and Menta Importent: If item 27 Is marked any injury or other treumatic ev		SHARON N. WILSON/ SISTER 19108 OLD DANS ROCK ROAD FROSTBURG, MD 21 20a. Method of Disposition 1 Burial 2 (X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) CUMBERLAND CREMATORY 10/19/06 CUMBERLAND,													
Ba	Depermine Depermine Important import		21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOWERS FUNERAL HOME, P.A. PROSTBURG 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,										RG, MD 215	32		
	Pnysician /Medical		shock, or heart failure Immediate Cause (Final disease or condition resulting in death)	. List only o	ne cause on	each line. Scpsis			odo or dym	9, 50011 05		Toophiatory t	211031,		Interval Between Onset and Death 2 weeks	h h
	Examiner	ē	Sequentially list conditions if any, leading to immediate		b	Carci	sequence of): sequence of):								6 months	5
,092	ate be executed hysician and he burial-transit	Ical Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ĺ	Due to	(or as a con	sequence of):									
0x 68	eath certificat attending phy I for use as th		IF FEMALE: 23b. Was decedent pregna	nt	23c. If yes, ou	tcome of pre		3□Ectopic	pregnancy					23d. Date of de		
P.O. B	at the dea I by the att	Physician/Med	in the past 12 months 1 Yes 2 No 9 Unknown		4□Preg 9□ Unkr	nant at time	of death	5 Other	(specify)					Month	Day Year	
Records,	The law requires that the death certifica te has been signed by the attending ph page 2 should be detached for use as it	by	Part II. Other significant co	onditions co	ntributing to d	leath but not	resulting in th	e underlyin	g cause give	en in Part I.					o the cause of death robably 4 Dunkno	
_		Completed										24a. Was auto perfi 1 Yes		prior to death?	utopsy findings availa completion of cause s 2 No	able of
Vit.	ysiciar is certif directo	To Be	25. Was case referred to mexaminer? 1 ☐ Yes 2 ☐ No	-	lospital:	fnpatient :	2 ☐ ER/Outpa	tient 3	DOA Oth			Check only		6 ∏Other (Spe	ocify)	
27. Manner of Death 28a. Date of Injury 28b. Time of Injury at Work? 28d. Describe how injury occurred 28d. Describe how injury occurred																
DIVIS	To the Hospitel or Attence within 24 hours after death To the Funerel Director: completely filled in by the	Certification:		Could not be determined	28e. Place build	e of Injury - A ing, etc. (Sp	At home, farm ecity)	street, fac	ory, office		28	Bf. Location (City or To			ural Route Number,	
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	Medical	29a. Certifier 1 Ce (Check only 2 Me one)	rtifying Phy dical Exemi	nar: On the b	e best of my basis of exam ner stated.	knowledge, d nination and/o	eath occurr r investigat	ed at the tin on, in my o	ne, date an pinion, dea	d place, ar th occurred	d due to the	cause(s , date and) and manner a d place, and du	s stated. e to the cause(s)	_
	To t	M	29b. Signature and title of c	ertifier)			29c. Licenso D] 32					te signed <i>(Mon</i>		
	12		30. Name and address of p	7 - 1												
	Sta	100	A. SIVAN PI 31. Date filed (Month, Day,			Registrar's Si	N DRIV		MBERL	AND,	MD 21	502		<u>. </u>		
	Registr	ar	GO A O D	_000	14 18	N AJ	A CONTRACTOR OF THE PARTY OF TH	36								

State of Maryland / Department of Health and Mental Hygien 35096 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Carol Marie Xander October 18, 2006 7:15 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Locetion of Death Examiner 2605 Zoll Lane Waldorf Charles 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2X□ F Director 219-42-4697 63 June 1943 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryla Deperment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Itame 23a or 28a-f ahov any injury or other traumatic event, Ira Medical Examinar must be notitied at once. 1 ☐ Yes 2 No Marvland Charles Waldorf Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2605 Zoll Lane 20603 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🗓 No Specify Specify Completed by 3 ☐ Widowed 4 ☒ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Realty Specialist US Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James A. Mattingly Florence Marie Adell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry A. Xander, III - Son 1409 Nassay Drive, Crofton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ABurial 2 Cremation 3 Removal from State Christ Church Cemetery 10-21-06 Accokeek, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee M00053 22. Name and Address of Facility 3035 Old Washington Rd Stokam Huntt Funeral Home POB 156, Waldorf, MD 20604 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Colon Cernce /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed for use es the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

↑□Live birth 2 □ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 ☐ Yes 2 000 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death | Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 ☐ Yes 2 😘 o 1 🗌 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After s after dea. 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) aman 13 OCTUBE/ 18,206 ddress of person who completed cause of death (Item 23a) (Type, Print) 11701 Livingion Rond Sul #101 Anna m illimn 32. Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 2 0 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 000

			State of Maryland	Departmer / Certificat	t of Health and I e <i>of Death</i>		jiene2 () ()6 3	5097	
Physic		1. Decedent's Name (First, Middle, Last) John Henr	Alstan			2. Dete of Dee Month	Dey	Year	ime of Death	
/Med Exam	iner	4a Fecility Neme (If not institution, give \$1.5 Social Security Number 6. Sex	reet end number) Medical C 7. Age (in yrs. lasi	fer birthdey) If Unde		Location of Death	4c. County o			
Director		214-14-1152 Usuel Residence of Decedent	M 2□ F 84	Yrs. Months	Days Hours Min.	(Month, Dey 03/28			SC	
Manylend f show	ō	10a. State 10b. County		own or Location				1.0	ide City Limits	
ith the ?	Director	MD 10e. Street end Number	BALT	IMORE 10f. Zip	Code		0g. Citizen of W	hat Country?		
1 5-UUZU 72 hours after death with the Maryland 72 hours after death with the Maryland *natural', or frems 23s or 28s-f show sideal Examiner must be notified at	by Funeral	1654 CLIFTVIEW AVE. 11. Maritel Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	2. Was Decedent Ever in U,S. Armed Forces? 1 ☆ Yes 2 ☐ No If Yes, Give Year or Dates:		213 Jent of Hispanic Origin? (S jify Cuban, Mexican, Puerl 2⊠No Specify:	pecify Yes or No- to Rican, etc.)	Black	- American Indi	an,	
Z1Z1 d within liene.	Completed by	15. Decedent's Educa (Specify only highest grade of Elementery/Secondary (0-12) 5TH	completed) College (1-4or 5+)	6e. Decedent's Usu (Give kind of wo life. DO NOT u	rk done during most of wo se retired)	rking	16b. Kind of Bus	,	LER	
Maryland 2 d 2 should be filed th end Mentel Hygie 7 la marked other traumatic event, I	To Be C	17. Fether's Neme (First, Middle, Last) DAVID ALSTON		TACON D			TRACTOR TRAILER rst, Middle, Maiden Sumame) N Pute Number, City or Town, State, Zip Code) ALITIMORE, MD 21213 late 20c. Location - City or Town, State			
Gore, Mary ges 1 and 2 shou t of Health end M If them 27 ia marl or other traumati		JOHNNIE L. ALSTON 20a. Method of Disposition	ORE, MD	21213						
Saltimo permit. Page Depertment of important: If any injury or once.		1 ⊠ Burial 2 □ Cremation 3 □ Rei 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	CR	OWNSVILLE 22. Name ar	d Address of Facility	11/3/06 SLEY CHA		VILLE,		
Physician /Medical Examiner		23a. Pert1. Enter the disease, of complice shock, or heart failure. Furt only one Immediate Cause (Final disease or condition resulting in death)	1	Do not enter the mod	e of dying, such as cardiac	AVE., BA	LTIMORE,	Appro	231 eximate al Between t and Death	
DUX 08/00, auth certificate be executed attending physician end for use es the burial-fransit	■ n/Medicai Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of):	yeloma					
. 5 e b	by Physician/M	Part II. Other significant conditions contri	ibuting to death but not resulting	ng in the underlying o	ause given in Part I.	23b. Did to	obacco use cont	ribute to the co	ause of death?	
s, r.C. se that the de gned by the be detached	by Ph					1 D Y	es 2 No	3 Probably	4 Lunknown	
requir been s	Completed					24a. Wes a perfor	in autopsy med?	24b. Were eut- available completio of death?	prior to on of cause	
an: The tifficete h	Be Col	25. Wes case referred to medical			26. Plece of Dec	1 □ Y		1 ☐ Yes	2 No	
OI VILLA Physician: this certific real director,	၉	examiner? 1 Yes 2 Ho		VOutpetient 3□ DO	Other: 4 Nursing H	lome 5□ Resid	ence 6 □Othe			
INVISION or Attanding fler deeth. Nivector: After in by the fune	Certification:	27. Manner of Death T Natural 2 Accident 3 Suicide 4 Homicide 2 Could not be determined	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home building, etc. (Specify)	М	8c. Injury et Work? 1 ☐ Yes 2 ☐ No		ow injury occurre treet and Numbe n, State)		ə Number,	
Hospital 24 hours e Funeral Coletely filled	edical Ce	29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Examine	sian: To the best of my knowle r: On the basis of exemination end manner stated.	dge, death occurred and/or investigation	at the time, date and place in my opinion, death occu	, and due to the c irred at the time, c	ause(s) and man ate and place, a	ner as stated. nd due to the ca	ause(s)	
To the within 2 To the comple	Me	29b. Signature and title of certifier	12 MD	29	D/9745		9d. Date signed		•	
Ø		30. Name and address of person who com	pleted cause of deeth (Item 23	Be) (Type, Print)	V19743 Street	Balx	mal	MA	21201	
St Regist	ate	31. Dete filed (Month, Day, Year)	3. Registrer's Signature							

	e)	For State Registrar	State of Maryla	,	artment of rtificate of		d Mental Hy	giene Reg. Na 20	006	35098		
Physici /Medic		1. Decedent's Name (First, Middle, Las Еdward	n Avall	one			2. Date of D. Month October	Day	Year 2006	3. Time of Death P 18:10 M		
Examin		4a Facility Name (If not institution, give Peninsula Regional 5. Social Security Number 6. Se	Medical Cen	rs. last birthday	5	or Location of E	u	4c. County of Death Wicanico of Birth 9. Birthplace (State or Fore)				
Funeral Director		201-10-1853 X	M 2□F B		Months Day		Min. May 2	1, 1917	917 Pennsylvania			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatin and Mental Hydiene. Department of Heatin and Mental Hydiene. The proprient: If Item 27 is marked other then "natural", or Items 23a or 28a-f show eny injury or other traumatic event, Ital Medical Examinar must be notified at appear.	Funeral Director	10a. State 10b. County MD Worces 10e. Street and Number		City, Town or L Ocean		,		10g. Citizen o	of What Count	Od. Inside City Limits 1 ☐ Yes 2 ☐ No try?		
eath with	eral D	13908 Fiesta Road	12. Was Decedent Ever in	1115 13	218		2 (Specify Ves or N		U.S.A.			
ours after d	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	13.	1 Yes 2 N		n? (Specify Yes or N Puerto Rican, etc.)	Spec	llack, White, e			
d within 72 h giene. pr then "natu	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		(Give	edent's Usual Occ e kind of work don DO NOT use retii PECTOR	e durina most of	f working	16b. Kind of	Business/ind			
uld be file Mental Hyg Irked otheral	To Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maider							·			
nd 2 sho alth and 1 27 is m		19a. Informant's Name/Relationship (7) Richard M. Avallo					or Aural Aoute Numb est Hill,		vn, State, Zip 050	Code)		
ages 1 a int of Heal		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐		n - City or To								
permit. P Departme Importan eny Injur.		4 ☐ Donation 5 ☑ Other (Specify 21. Signature of Funeral Service Licen	william G.	Dau 2	2. Name and Add	ress of Facility	1/03/06 Ruck Tows: owson, MD	on Fune:	ium, M ral Ho			
Physician /Medical Examiner	Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Be Onset and disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, and any location of the conditions of the conditions of the conditions. Due to (or as a consequence of):										
othe Hospital or Attending Physician: The law requires their the death certificate be executed within 24 hours after death. The following the following physician and the following physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical	that initiated events resulting in death) Last	Due to (or as a cons	sequence of):								
w requires thet the death certific been signed by the ettending p should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of 9 □ Unknown	etal death 3	□Ectopic pregnar □ Other <i>(specify)</i>				Date of delive Month	ry Day Year		
equires thet en signed b	þ	Part II. Dther significant conditions or	entributing to death but not	resulting in the o	underlying cause (given in Part I.		tobacco use co		e cause of death? ably 4 Dunknown		
The law ricete hes be	Completed	Premmonia					24a. Wa auto peri 1 ☐ Yes	s an 24l ppsy ormed 2 No	prior to con death?	osy findings available inpletion of cause of 2 No		
ysiciai s certii directo	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	! ☐ ER/Outpatie	ent 3 DOA		f Death Check only ing Home 5 Res		Other (Specify	•)		
nding Ph tth. r: After th e funeral	atlon: T	27. Many of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year		of 28c. In		28d. Describe	how injury occ		,		
To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: Atter this certificate hes completely filled in by the funeral director, page 2.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, si	treet, factory, offic	е		(Street and Number) Swn, State)	mber or Rural	Route Number,		
he Hospi in 24 hour he Funer pletely fill	edical	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysicien: To the best of my tiner: On the basis of exam and manner stated.	knowledge, dea ination and/or i	th occurred at the nvestigation, in my	time, date and p popinion, death	place, and due to the occurred at the time	cause(s) and , date and plac	manner as st	ated. the cause(s)		
To t To tl	Σ	29b. Signature and little of certifie	~ mp			nse number		29d. Date sig	ned (Month, L	Day, Year)		
67		30. Name and address of person who of	completed cause of death (I	Item 23a) (Type	, Print)							
Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Sig	gnature	Shoull s	J 77.01.	sbury me					

State of Maryland / Department of Health and Mental Hygien 0 0 6 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 9:55 **Physician** Year Gloria C. Blount 10/29/2006 /Medical 4a. Facility Name (If not institution, give street and number)
Gladys Spellman Speciality Hospital
and Nursing Center 4b. City, Town, or Location of Death 4c. County of Death Examiner Cheverly Prince George's 5. Social Security Numbe 030–14–2807 If Under 1 Year | ff Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)
 MA **Funeral** 1 □ M 2 🔀 F 82 Director 09/05/1924 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 23a or 28e-f show the Medical Examiner must be notified at VA Prince William Woodbridge Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 12516 Bentley Circle 22192 USA death Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: American 1 Never Married 2 Marned ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify: þ Specify 3 ☐ Widowed 4 Divorced Indian natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry State Of Elementary/Secondary (0-12) Coffege (1-4or 5+) Massachusetts elevator Operator 12 other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other traumatic event QRGE. Be Thomas Scottron Georgenia Asberry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jasper Blount / Son 13516 Bentley Circle, Woodbridge, VA 22192 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Oaklawn Cemetery 11/9/2006 Boston, MA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signuture of Funeral Service Licensee 22. Name and Address of Facility Charles L. Stevens Funeral Home Inc. 1501 Fast Fort Avenue, Baltimore, MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Multiple Myeloma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of). Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy been signed by the attershould be detached for in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? respiratory failure 1 ∏Yes 2 XXNo 3 Probably 4 Unknown Chronic Renal Failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 22 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No within 24 hours after deeth.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 TNo 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11/03/2006 D0026024 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6490 Landover Road, Suite F, Landover, MD 20785 Lester Miles M. D. 32. Rastrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

NOV 0 6 2006

AMEND TTEM#10e perFH G861 11/6/06 WS State of Maryland Department of Health and Mental Hygiene Registrer Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 555 AM Granville 2006 October 31 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Hospita Baltimore Hockins Johns 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min 1 XM 2 ☐ F 52 093-46-4136 Yrs. 07/05/1954 WASHINGTON DC Director Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location rthen "naturel", or Iteme 23s or 28e-f ehow the Medical Examiner coust be notified at BALTIMORE CITY N/A 1 XYes 2 No MD Director 10e. Street and NumberCLTFIVIEW 10g. Citizen of What Country? 10f. Zip Code 1303 CLILIFTVIEW AVENUE 21218 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes W☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Never Married 2 Married 1 ☐ Yes 2 X No Specify: BLACK þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working (life. DO NOT use retired) CITY OF BALTIMORE Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 end 2 should be filed within Depertment of Heelth and Mental Hyglene. Important: If Item 27 is marked other then apply injury or other treumatic event, The MODE. SANITATION WORKER 10TH 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) GRANVILLE BROWN MARIE HARRON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1303 CLIFTVIEW AVE., BALTIMORE, MD 21218 SHAKEARA BROWN / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Anne Arunder MCO. ING MEM PARK 11/08/06 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 21. Signature of Tuneral Service Licensee 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD Enter the divease, or complications that caused the death. On not enter the mode of dying, such as cardiac or respiratory arrest or learn fature. List only one cause on each line. Approximate Interval Between Onset and Death Immediate cause (Final disease condition resulting in death) Hear Decompensated Physician /Medical Due to (or as a consequence of) Examiner 2 weeks Sepsis if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-transit Due to (or as a consequence of). Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To 28a. Date of Injury (Month, Day Year) After the 28c. Injury at Work? 27 Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No ours after death. nerel Director; A filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division of Vital Records, P.O. Attending Physicien: death. ö To the Hospital within 24 hours a To the Funerel C

The law requires that the death certificate be executed

Box 68760,

with the Maryland

deeth 1

filed within 72 hours after

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month

29h Signature and title of certifier

Munoz,

The

2006

Pay, Year)

Johns Hopkins Hospital, 600 North Wolfe Street, Baltimore Maryland 32 Registrar's Signature Burn

Daniel Munoz, Metical Doctor

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

RES-00

29d. Date signed (Month, Day, Year)

06-08120 Please Type or Print in Black Indelible Ink Timothy Booker State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2 Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ TIMOTHY BOOKER Month Day October 28, 2006 1607 hrs **Medical Examiner** 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore N/A 5. Social Security Number 7. Age (In yrs last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9 Birthplace (State or **Funeral** Months Davs Hours oreign Courte ARYLAND Director 218-78-6171 1 X M 2 F 45 04/10/1961 Usual Residence of Decedent any 10a. State 10c. City, Town or Location 10d Inside City Limits N/A MD or 28a-f show BALTIMORE CITY 1 X Yes 2 No death with the Maryland Director 10e. Street and Number fied at 0 10f. Zip Code 10g Citizen of What Country? 1838 E. 29TH STREET 21218 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Armed Forces? Married Yes Pages I and 2 should be filed within 72 hours after onen of Health and Mental Hygiene and I filem 27 is marked other than "natural", one other traumatic event, the Medical Examiner. BLACK 3 Widowed Divorced If Yes, Give Year Yes 2 X No specify þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) COOK Baltimore, MD 21215-0036 12TH FOOD SERVICE 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) CORNELIUS BOOKER PATRICIA PASCHALL 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICIA BOOKER/MOTHER 1838 E. 29TH ST., BALTIMORE, MD 21218 20a Method of Disposition 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State or other 1 Burial 2 X Cremation 3 Removal from State METRO CREMATORY 11/06/06 permit Page
Department o
Important: CATONSVILLE, MD Donation 5 Other Specify 21. Signa Fif Funeral Service Licen 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE disease, of th. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart compli **Physician** Approximate Interval alure List o v one cause on each line Between Onset and /Medical Death Narcotic intoxication (heroin) te Cause (Final disease Examiner ndition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause Enter Underlying Cause (ami (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Ж and Physician/Medical X UNPENDED attending physician or use as the burial **AMENDED** #23a.27 28a-f perME. 11/27/06 TT Division of Vital Records, P.O. Box 68760, IF FEMALE If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 2 No 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital. 1 Inpatient 2 🗸 ER/Outpatient 3 Other₄ this DOA Nursing Home 5 Residence 6 1 🗸 Yes 2 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Fnd 10/28/2006 Fnd 3:30 pm unknown 2 Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1838 East 29th Street Baltimore, MD 6 X Could not be Suicide within 24 hours a To the Funeral I (Specify) other-scene Homicide 29a Certifier (Check only) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b Signature and title of certifie 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E. October 29, 2006 30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) State NOV Registra

DHMH 17 Rev 1/2001 OCMF 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] 1- State Amend item#15,16a, perFH, g861, 11/28/entificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Margaret Broderick **Physician** Month Year October 31 2006 2:50p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Holy Cross Nursing & Rehab Burtonsville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) March 26 1908 Birthplace (State or Foreign Country) **Funeral** 1□M 2ਊF 98 185-26-2669 Yrs Director PA Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Md Carroll Sykesville 1 Yes 2 No Be Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6506 Church Street 21784 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Yes 2 ☑ No If Yes, Give A Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify: Specify.white 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Dccupation
(Give kind of work done during most of working life. DO NOT use retired)

Development 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) -volunteer charities Coordinator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Sarah Brady Francis Mooney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6506 Church St., Sykesville, MD 21784 Sally Trayer-Mace (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page Department o Important: if any Injury or once. 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Springfield Cemetery 11-4-06 Sykesville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityHaight Funeral Home & Chapel ▶ Paige Haight o erwert P.O. Box 195, Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Advance /Medical Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 🗷 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide

Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit Division of Vital Records, P.O. Box 68760, signed by the attending phys be deteched for use as the page 2 To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funeral Director; After this certification completely filled in by the funeral director, Medical

filed within 72 hours after deeth with the Maryland

Baltimore, Maryland 21215-0036

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

. Pages 1 and 2 should be filed v tment of Health and Mental Hygie tant: if itam 27 is marked other t jury or other traumatic avent, ib

State

29a Certifier

29b. Signature and title of certifier

31. Date filed (MDM)

DHMH 17 Rev 1/2001

and manner stated.

1220 A East Registrar's Sime

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bucgaville

6 2006

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0054566

ppa Road scein 230 Toward MD21286

29d. Date signed (Month, Day, Year)

06-08229 Please Type or Print in Black Indelible Ink Lascelles Bolt State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day October 31, 2006 Medical Examiner ascell 0904 hrs 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) 5306 Cordelia Avenue **Baltimore** If Under 1 Year | If Under 24Hrs. | 8. Date of Birth(MM/DD/YYY 9. Birthplace (State or 7. Age (In yrs. last birthday) Funeral Foreign Country) Days Hours Director 2 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show e notified at once. Yes 2 No Baltimore Pages I and 2 should be filed within 72 hours after death with the Maryland Funeral Director 10f. Zip Code 10g. Citizen of What Country Street and Numbe USA 21215 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11 Marital Status Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married Yes Specify: Black Divorced Widowed If Yes, Give Year No specify: à 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry marked other than "natur c event, the Medical Exam Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 Private of Health and Mental Hygiene. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bertran INNETE 19a. Informant's Name/Relationship (Ty 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 183 24 nt: If item 27 is n other traumatic ston 20b. Place of Disposition (Name of cemetery Date 20a. Method of Disposition crematory or other place) 2 Cremation 3 portant: WOODE AWN, Me MEmorial Donation 5 Other Specify: 21. Signatu of Funeral Service Ligenses 22. Name and Address of Facility Chatman - Harris Funeral Home 5240 historstown Ad Baltimore er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and ure. List only one cause on each line /Medical Death Hypertensive atherosclerotic cardiovascular disease immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed and Physician/Medical X UNPENDED attending physician or use as the burial -AMENDED #23a,27,perME IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? Day Live birth 3 Ectopic pregnancy Month Fetal death Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Yes 2 ✓ No 3 Probably 4 Unknown Be Completed 24a. Was an 24b. Were autopsy findings available

Division of Vital Records, P.O. Box 68760. After this certificate has To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi Certification: To

				performed?	death?	2 No
. Was case referred to medical		26.Pia	ce of Death (Check	only one)		
examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3 DOA	Other Nursin	ng Home 5 Residence	e 6 🗸 Other: Scene	
'. Manner of Death	28a. Date of Injury	28b. Time of Injury 28c. Ir	njury at Work?	28d. Describe how injury	occurred	
X Natural 5 Pend	(Month, Day, Year)	1	Yes 2 No			
	tigation					
Suicide 6 Coule	not be 28e. Place of Injury - At I	home, farm, street, factory, office	e building, etc.	28f. Location (Street and or Town, State)	Number or Rural Route I	Number, City

O.C.M.E.

determined (Specify) Homicide 29a. Certifier (Check only

NOV 0

29b. Signature and title of

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number 29d. Date signed (Month, Day, Year)

November 1, 2006

Year

30. Name and address of person who completed cause of death (Item 23a)

2006

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Susan Hogan MD.

31. Date filed (Month, Day, Year) State Registra

Medical

		For State Registrar	State of Maryland			t of Health a e of Death	ınd Me		ene	006	3510) 4
		1. Decedent's Name (First, Middle, Last)					2	Date of Death	Day	Year	3. Time of Dea	ath
Physicia /Medic		LEONID			BOR	UKHOV		CTOBER	30	2006	19:25	М
Examin	er	4a. Facility Name (If not institution, give st				4b. City, Town, or Location of Death			4c. County of Death			
		THE JOHNS HOPKINS 5. Social Security Number 6. Sex	7. Age (In yrs. las	st birthdav)	If Under	TIMORE	24 Hrs. 8	Date of Birth		N/	nolace (State or Fo	oreian
Funeral Director			^{M 2□ F} 58	Yrs.	Months	Days Hours	Min.	(Month, Day, 0/30/194	Year) 18	Co	UKRAINI	_
p .		Usual Residence of Decedent		Tour celo	antina					10d. Inside City Limits		
ehow	ō	10a. State 10b. County		Town or Lo							1 ☐ Yes &	
the N	Director	MD BALTIMOR 10e, Street and Number	(E	OMIN	GS MI			10	g. Citiz	en of What Co	^	
3s or		2409 VELVET VALLEY	/ WAY			21117				U.S.A.		
death	Funerai	11. Marital Status	Was Decedent Ever in U.S. Armed Forces?	. 13. V	Nas Deced	lent of Hispanic Orig	in? (Specif	fy Yes or No-	1-	4. Race - Ame Black, White		
-UU36 hours effer death with the Maryland turel; or iteme 23s or 28e-f ehow at Exerciner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give X		Yes			, , , , ,	5		WHITE	
15-0036 72 hours efter death with the Maryla "naturel", or iteme 23a or 28e-1 ehov adical Examinat must be notified at	ed b	15. Decedent's Educ	Year or Dates:	16a. Deced	tent's Usua	al Occupation		1	6b. Kin	d of Business/	Industry	
within 72 ene. then "net	piet	(Specify only highest grade Elementary/Secondary (0-12)		(Give		rk done durina most	of working	'			,	
d 21.	Completed	Listing italy/obcordary (0 12)		AUT0	MECHA	NIC		/	AUTO	MOTIVE	REPAIRS	
€ dage ⊒	Be	17. Father's Name (First, Middle, Last)	D.O.	אואוומי	V			First, Middle, M	aiden S		LAAA NI	
Maryla d 2 should th and Men 7 is marke traumatic	은	ION 19a. Informant's Name/Relationship (Typ.		RUKHO		(Street and Numbe		Poute Number	City or	BRIS		
Mar id 2 sho ith and ith and 27 is m	9	NATALYA VISHNEVSKY			-	T VALLEY			-			
other to		20a. Method of Disposition		ice of Dispo	sition (Nan	ne of ther place)	Dat	e 2	0c. Loc	ation - City or	Town, State	
		1 N Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	D RID	,		/02/2	2006 BA	ALTI	MORE,	MD	
Baitimc permit. Page Depertment importent: if any injury or		21. Signature Funeral Service Licens		22	. Name an	d Address of Facility	SOL	LEVINS	N 8	BROS.	, INC.	
0 82E48		precedent	myer			REISTERSTO	OWN RC	DAD - P	IKES		MD 21208	3
		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	e cause on each line.	Do not ente	er the mod	e of dying, such as	cardiac or r	espiratory arre	st,		Approximate Interval Betwee Onset and Dear	
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		IRATO	RY FA	ILURE					1 DAY	
Examiner			Due to (or as a conseque	R FAI	LUDE						1 MONTH	Ц
	Jer	S-quentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque		LUKL						I MONTI	
nd transit	Examin	Cause (Disease or injury that initiated events		METASTATIC GASTRIC CANCER							22 MONTH	
8760, A		resulting in death) Last	Due to (or as a conseque	ence of):								
ate ate	dicai	d.										
BOX 61	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnan						23	3d. Date of deli	verv	
Geath cer death cer e ettendin d for use	Iclar	in the past 12 months?	1 Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea		Ectopic pr Other (sp					Month	Day Year	r
P.O.	hys	9 🗆 Unknown	9□ Unknown									
Division of Vital Records, P.O. Box 6i or Attending Physician: The law requires that the death certific effer death. Director: After this certificate has been signed by the ettending p in by the funeral director, page 2 should be detached for use as	ρ	Part II. Other significant conditions con ASCITES	tributing to death but not result	ting in the u	nderlying c	ause given in Part I.		23e. Did toba			the cause of death	
aw req	Completed	LYMPHEDI	EMA					24a. Was an		24b. Were au	topsy findings ava completion of caus	ılable
al Rec	E							autopsy perform	ed?	death?	completion of caus 2. ✓ No	e of
Vital F sicien: Th certificate	BeC	25. Was case referred to medical examiner?				26. Place	of Death (Check only one	_			
Vision of Vita Attending Physician: r death. ector: After this certifica by the funeral director.	۵,	1 ☐ Yes 2 💆 No		R/Outpatien				5 Resider			cify)	
ding F h. After funer	ion:	27. Manner of Death 1 Natural 5 ☐ Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 2	28c. Injury at Work? 1 ☐ Yes 2 ☐ I	1	d. Describe how	v injury	occurred		
Division or Attendi of a ter death. Director: A in by the fu	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At horn	ne, farm, str						Number or Ru	ral Route Number	;
Div	Certification;	4 Homicide determined	building, etc. (Specify)					City or Town,	State)			
Div To the Hospital or within 24 hours effe To the Funeral Dir completely filled in I	edicai (iciam To the best of my know ter: On the basis of examination and manner stated.									
To the Forthin Somple	Me	29b. Signature and title of certifier			290	. License number		29	d. Date	signed (Monti	h, Day, Year)	
		MIXA				RES -	- 000		ИОЛ	EMBER	3, 2006	
6	10	30. Name and a 17 as of person who co				TIMODE &	4D 21	1207				
1			00 N. WOLFE ST		- RAL	I I I MUKE, N	נ אינוי.	128/				
Sta Registr		31. Date filed (Month, Day, Year) NOV 0 6 2006	32. Registrar's Signatu	San Contraction of the Contracti								

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Reg. No.2006 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Year COLEMAN Month November Day **Physician** DORRIS. 12-40 PM 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11948 Simpson Road Clarksville Howard If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖫 F 91 306-42-5296 Yrs 09/03/1915 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow the Medical Examiner must be notified at MD Howard Clarksville 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 11948 Simpson Road USA 21029 Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☑★0 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No þ 3√2 Widowed 4 □ Divorced "naturel", Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: if Item 27 is marked other it any injury or other traumatic event, ILS Once. 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clarence Murray Fern Hackman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Barbara Coleman / Daughter 11948 Simpson Road, Clarksville, MD 21029 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20a. Method of Disposition 20c. Location - City or Town, State 11/11/2006 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Indianapolis, IN 4 □Donation 5 □ Other (Specify) Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Charles L. Stevens Funeral Home Inc. 501 East Fort Avenue, Baltimore, MD 21230 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Renal Acute One Week /Medical Due to (or as a consequence of): Examiner fancreatitis Four week Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): ed by the attending physician detached for use as the burial Box 68760. by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, tate has been significant DISEARCE CORONARY BRIERY 1 Yes 2 No 3 Probably 4 Unknown Be Completed HTP2 RTEASION 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a Was an SENILE DEMENTIA. 2 V No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 1 V Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide within 24 hours a To the Funerel C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. ÷ 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2006 D-30469 November 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. B. VELLANKI. 8850, COLUMBIA, 100 Ponkway 4 303 COLUMBIA. MD. 21045. N.BVELLANKI. 8850, 31. Date filed (Month, Day, Year) NOV 0 6 2006 Registrar

State of Maryland / Department of Health and Mental Hygien 2006

35106

						Cei	rtificate of	t Death		Re	g. No.			
			1. Decedent's Name (First, Middle	, Last)						Date of Death			3. Time of Death	
	Physici		WALTER JAN	MES CARTE	ìR				No	Month Svember	Day 20	Year 106	10:45 A	
	/Medid Examir		4a. Facility Name (If not institution					4b. City, To	wn, or Location		4c. County		10.47 A	
1	Exami	lei		_				Parky					County	
			OAK CREST VILLAGE: HEALTHCARE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year						Date of Birth					
	Funeral Director			1⊠M 2□F	89	Yrs.	Months Day		Min. (Date of Birth Month, Day, 11y 25	Year)	Count	ace (State or Foreign ry) 'Land	
100	Director	8 3	216-01-9137 Usual Residence of Decedent		09				J	шу 43,	, 1917	Mary	Tand	
	and w		10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10	d. Inside City Limits	
	f she	5	Maryland Baltim	ore Coun	t 57	Parky	71110						1 ☐ Yes 21 No	
	28a-	5	10e. Street and Number	ore coun	Ly	Idiki					0'''			
	Mit So	Funeral Director	8832 Walter Bo	1			10f. Zip Code			10	g. Citizen of V		ry?	
	s 23	rai						21234			US			
	er de	Š	11. Marital Status	Armed F		,S. 13. \	Was Decedent of f Yes, specify Cu	Hispanic Origi ban, Mexican	gin? (Specify n, Puerto Rica	Yes or No- in, etc.)		e - America k, White, e		
20	or l	by F	1 Never Married 2 Marri	ed 1 X Yes If Yes, G	2 □ No ive		1 □ Yes 2 ☑ No	Specify:	ocify: Specify:				te	
21215-0020	ural'	d D	3 ☐ Widowed 4 ☐ Divorced	Year or I	Dates:						-,,	ANIT		
7	be filed within 72 hours after death with the Maryland Hygiene. A Hygiene. d other than "natural", or Items 23a or 28a-f show event, I're Medical Examiner must be notified a	Completed	15. Decedent (Specify only highes	's Education <i>t grade</i> com <i>pleted,</i>)	16a. Deced	dent's Usual Occi kind of work don DO NOT use retir	upation e <i>d</i> u <i>ring</i> mo <i>st</i>	t of working	11	6b. Kind of Bu	ustry		
2		臣	Elementary/Secondary (0-12)	College	(1-4or 5+)			red)		74				
N		S	12th			Tec	hnician				-		cations	
ב		Be	17. Father's Name (First, Middle, I	Lest)				18. Mothe	er's Name <i>(Fir</i>	rst, Middle, Ma	aiden Surnam	e)		
$\frac{8}{2}$	Men Arrica attic	2	Maurice A. Car	rter				Ly	dia		Sim	าร		
Maryland	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationsh	, , ,		19b. Mailir	ng Address (Street	et end Numbe	er or Rural Ro	ute Number,	City or Town,	State, Zip (Code)	
≥ `			Wayne C. Mason	(Nep	hew)	1217	St. Fra	ncis R	Road, Bel Air, Ma			aryland 21014-20		
Ze			20a. Method of Disposition		20b. F	Place of Dispo	sition (Name of natory or other pi	(ace)	Da	ate 20	Oc. Location -	City or Tow	n, State	
Ĕ			1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		State		ce U. Me		a. 11/	16/2006	ozwso	n. Ma	aryland	
Baltimore,			21. Signature of Funeral S	icensee		22	. Name and Add	ress of Facility	y		6			
Ö	Depa Depa Impo any ir	b) 0	Martin D	awson)	M	itchell-	Wiedef	feld Fu	neral	Home,	Inc.		
	1 1				caused the deat	h Do not ent	500 York	Road,	Balti	Lmore,	Maryla	1 nd $_{\downarrow}21$	212 Approximate	
	DI1-1-	ac 1	23a. Part1. Enter the disease, or shock, or heart failure. List of	only one cause on	each line.	20	رم المال المال المال المال	, ing, saon as	ourdido or res	spiratory arros	,,,		Interval Between Onset and Death	
	Physician /Medical		Immediate Cause (Final		Aco	unt	, , ,	200.				1		
	Examiner		disease or condition resulting in death)	Θ	112	1 MAT	un	rica	hon	K				
-0		ᡖ			Due to (c	r as a conseq	uence of):							
1	nsit	an/Medical Examiner	a may a mi	b	12 11 10 7		, ,							
V	Attending Physician: The law requires that the death certificate be executed at death. The factor. Attentities that been signed by the attending physician and ector. Attentities the buriel-transit by the funeral director, page 2 should be detached for use as the buriel-transit.	Xa	Sequentially list conditions, if Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying								1			
9	be e siciar buri	le le	Cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of):											
ox 68760,	icete phys s the	퓿	resulting in death) Last Due to (or as a consequence of):									į		
×	ding	Š	d											
B	atten	ä										1		
О	at the	Physici	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								,	,	the cause of death?	
۵.	het ti ed by detar		Demer	itia						1 🗌 Yes	2 3 NO	3 Proba	abiy 4 🗆 Unknown	
Š,	sign sign	<u>5</u>												
0	requ houli	ě							1	24a. Was an performe		avai	e autopsy findings lable prior to	
e	law nast 92s	훁							_			of de	pletion of cause eath?	
=	The ate page	Completed								1 ☐ Yes	2 No	1 🗆	Yes 2□ No	
≅	lan: artific ctor,	Be	25. Wes case referred to medical examiner?					26. Plece	of Death (Ch	eck only one)]			
<u> </u>	yslo iis ce I dire	ဥ	1 Yes 2 1 10	Hospital: 1 □	Inpatient 2	ER/Outpatien	t 3 DOA	ther: 4 Nur	rsing Home	5 Residen	ce 6 □Othe	r (Specify)		
0	ig Pt tertt nera		27. Menner of Death 1 ■ Natural 5 ■ Pending	28a. Dete	of Injury oth, Day Year)	28b. Time of Injury	28c. Inje	ury at	28d. I	Describe how	injury occurre	ed		
<u> </u>	ath. W:: Af	atic	2 Accident investig	ation		,,		∃Yes 2□N	No					
Division of Vital Records,	Atte er de ecto by ti	E E	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 289. Place	e of Injury - At ho ling, etc. (Specify	me, farm, stre	et, factory, office)	28f. L	ocation (Stre	et and Numbe	er or Rural i	Route Number,	
٥	ed in Del	Certification:			g, oto. (<i>Opcon</i>)	,,				ony or 101111,	0.0.07			
	To the Hospital or Attending Physician: The law within 24 Hours effer death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 Certifying	Physician: To the examiner: On the b	best of my kno	wledge, death	occurred at the t	ime, date and	plece, and d	lue to the ceu	se(s) and mar	ner as sta	ted.	
	he H in 24 he Fi	edical	one)	and mar	ner stated.	lion and/or inv	estigation, an my	opinion, deat	in occurred at	the time, date	e and place, a	na aue to t	ne ceuse(s)	
	Vith Com	Σ	29b. Signature and title of certifier	1			29c. Licer	nse number		290	. Date signed	(Month, Da	ay, Yeer)	
			> Trux	(m)			133	2896		-	11/2/	06		
	17.		30 Name and address of person v	no completed cau	se of death (Item	23a) (T ype)	Print) /) ,	11		1	^		
	12		Halamaga	8500 C	Nalth	اكامه	Va t	anta	Ille.	M) ?	2(23	ψ		
	Sta	te	31. Date filed (Month, Day, Year)	32,1	egistrar's Signa	turo	Land					1		
	Registr	_	NOV 0 6	2006	ALLES A	" Go	sells.							
DHA	H 16 Doy 6/0			-										

		1	State of Maryland / Department State of Maryland / Department State of Maryland / Department Certificate	t of Health and M e of Death		ne n2006	35107					
	Physicia		1. Decedent's Name (First, Middle, Last) (2) W William Colqhe now		2. Date of Death Month	Day 2 , 2 of Sar	3. Time of Death					
	/Medic	al -		Town, or Location of Death	Vormber	4c. County of Death						
	LXdillill	3	5 Social Security Number 6 Sex Age (In vrs. last birthday) If Under	1 Year If Under 24 Hrs.		(2W2)						
	Funeral Director		5. Social Security Number $\begin{array}{c ccccccccccccccccccccccccccccccccccc$	Days Hours Min.	8. Date of Birth (Month, Day, You Oct 29 1	ear) Coun	lace (State or Foreign try)					
	and and	⊢	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			1	0d. Inside City Limits					
	e Mary	ctor	Md Baltimore Woodlawn				1 ☐ Yes 2 📉 No					
	th with the	Funeral Director	7312 Windsor Mill Road 10f. Zip 2	Code 21244	10g	, Citizen of What Cour USA	itry?					
39	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural," or Itams 23a or 28a-f show aumatic event, the Medical Exacting at must be rediffed at	by Funer	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Noivorced 12. Was Decedent Ever in U.S. Armed Forces? 1 954- 14 Yes, Give Year or Dates: 1957	lent of Hispanic Origin? (Spirify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.					
21215-0036		Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usua (Give kind of wor life. DO NOT us 1 aborer	rk done during most of work	ing 16	b. Kind of Business/Industry Masonry						
N		To Be Co	17. Father's Name (First, Middle, Last) Floyd Edgar Coughenour		e (First, Middle, Mai trosnider	diddle, Maiden Sumame)						
Σ	s 1 and 2 should ba f Health and Mental ftam 27 is markad o othar traumatic eve			(Street and Number or Rur erty Rd., Ran								
Baltimore,	permit. Pages 1 and 2 Department of Health Important: If Itam 27 i any Injury or othar tre once.		A. Method of Disposition 1 Date 20c. Location - City or Town, State cemetary, crematory or other place) LaFayette Memorial 20c. Location - City or Town, State Brier Hill, PA									
Balti	permit. Departn Imports any Inju		1 63a 64a / 1 101a 1 a 1	d Address of Facility Haiox 195 Sykesv	_		Chapel					
	Pnysician /Medical Examiner	her	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mod shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	e of dying, such as cardiac	or respiratory arrest		Approximate Interval Between Onset and Death					
8760,	the death certificate be executed yithe attending physicien and iched for use as the burial-transit	dical Examine	that initiated events resulting in death) Last C									
.O. Box 6	it the death certific by the attending p tached for use as	Physician/Me	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (sp. 9 Unknown 1 Unknown 1 Ectopic pregnant at time of death 5 Other (sp. 9 Unknown 1 Ectopic pregnant 1 Ectopic pregnant 2 Ectopic pre			23d. Date of delive Month	ery Day Year					
ecords, P.	quires that n signad b uld be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying c	ause given in Part I,	23e. Did tobac	cco use contribute to the	ne cause of death?					
I Reco	The law requires that sate has been signad b page 2 should be deta	Completed	Ц		24a. Was an autopsy performe	prior to co	psy findings available mpletion of cause of					
Vital R	certific rector.	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DC	Other	h (Check only one)	ce 6 □Other (Specif	(v)					
lon of	ing After une	injury occurred	y)									
Division	in Dirt	et and Number or Rura State)	al Route Number,									
	To the Hospital or within 24 hours afte To the Funeral Dir. completely filled in I	Medical Certification:	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	, in my opinion, death occur	red at the time, date	e and place, and due to	the cause(s)					
	Ton	Σ	I some of seel mo	c. License number	290	Date signed (Month,	3, 2006.					
1			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	- Suite 35	7 v + 5 m	ninster	Ma 2/157.					
	Sta Regist		31. Date filed (Month, Day, Year) NOV 0 6 2006	,								

State of Maryland / Department of Health and Mental Hygien [] For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** EMONS 10.30.2006 12:45 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4c. County of Death 2931 FOREST GLEN ROAD BALTIMORE NA If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 03 · 16 · 1947 Birthplace (State or Foreign Country) **Funeral** 180 M 2 F Director 223.62.1051 NC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits th and Mental Hygiene. 27 is marked other then "naturel", or Iteme 23a or 28a-f shov traumatic event, the Medical Examinar must be notified at **Funeral Director** MD NA 1 XYes 2 No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2931 FOREST GLEN 21216 permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene Important: If item 27 is marked other then "nature!, or iteme 23a any injury or other traumatic event, the Medical Examiner cuts.) ROAD USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Efementary/Secondary (0-12) Coflege (1-4or 5+) 12/14 GRADE NA BUS DRIVER MTA 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) ALBERT CLEMONS BERTHA WINBORN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2931 FOREST GLEN RD. MILLORED CLEMONS (WIFE) BALTO. MD 21216 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MT. PLEASANT BAPT. CHURCH 111-06.06 HARREUSVILLE, NC 21. Sign ture of Funeral Service Licensee 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL PIKE, BALTO. MD 21229 Vaughn 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Land Duas /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): use es the burial-transity The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. ed by the attending physicien detached for use es the burial Physician/Medical IF FEMALE: 23c. ff yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of defivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death Month Year Day P.O. 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 23e. Did tobacco use confibute to the cause of death? this certificate has been signed at director, page 2 should be 2- No 3 Probably 4 □Unknown 1 Tes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Division of Vital 1 Yes 2 1 ☐ Yes 2 ☐ No fo the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only ope Hospitaf: Certification: To Other: 4 Nursing Home 5 Tesidence 6 Other (Specify) 1 Yes 2 ™No 1 fnpatient 2 EN/Outpatient 3 DOA After thi 27. Manner Weath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Maturaf 5 Pending within 24 hours after death. To the Funeral Director: A Director: / investigation 2 Accident 1 Yes 2 No 6 ☐ Could not Je 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 - Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2. Madreal Examinar. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 431615 30. Name and address of person who completed dause of death (ftem 23a) (Type, Print) walke V Lasto of 31. Date filed (Month 32 Registrar's Signature State 2006 Registra 1000

			For State Registrar	State of Marylan	•		nt of Health a te of Death	and Mer		iene	006	35109	
			Decedent's Name (First, Middle, Last)					2.	Date of Deat	h		3. Time of Death	
	Physici /Medio		ESTELLE	COLE				0	Month CTOBER	Day 3(2006	1758 P M	
	Examir		4a. Facility Name (If not institution, give st	reet and number)		4b. City	, Town, or Location o	of Death		4c. C	ounty of Deat	h	
			NORTHWEST	HOSPITAL		1.	RAN PALLS			4	BALTIM		
	Funeral Director		5. Social Security Number 6. Sex 218-34-6785 1□	7. Age (In yrs.	last birthday) Yrs.	If Unde Months	Days Hours	Min.	Date of Birth (Month, Day, 05/03/	Year)	9. Birt Co	hplace (State or Foreign untry) MD	
	pur *		Usual Residence of Decedent 10a. State 10b. County	10c Cit	v. Town or Lo	cation						10d. Inside City Limits	
	Aaryla	ក	115									1 ☑ Yes 2 ☐ No	
	28a-	Director	10e. Street and Number	Dai	timor		p Code		1	Og. Citize	n of What Co	untry?	
	With Ba or		2030 N. Wolfe	61.						15 A	iii oi ttilat oo		
	me 2:	Funeral	5,000	2. Was Decedent Ever in U		Was Dece	al 3 edent of Hispanic Orig	gin? (Specify	y Yes or No-	11	. Race - Ame		
36	d 2 should be filed within 72 hours after deeth with the Maryland in and Mantal Hyglene. It is marked other than "retural", or itame 23a or 28a-f show traumatic event, the Madical Exeminar must be notified at	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		if Yes, sp 1 ☐ Yes	ecify Cuban, Mexican 212 No Specify:		an, etc.)	s	Black, White	e, etc.	
21215-0036	2 hou	ed	15. Decedent's Educ	ation	16a. Dece	dent's Usi	ual Occupation			16b. King	of Business/	Industry	
215	nin 72	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give life.	kind of w DO NOT	ork done during most use retired)	t of working				,	
212	filed with Hygiene. ther ther	ĕ	Elementary/Secondary (0-12)	year	Anal	yst.				Soc	ial S	ecurity	
b	2 should be filed and Mental Hygia is marked other aumatic event, it	Bec	17. Father's Name (First, Middle, Last)			,	18. Mothe	er's Name <i>(F</i>	First, Middle, N				
<u>la</u> ı	should be ind Mental s marked o umatic sve	ဦ	James Joseph Po	arker Sr.			Bess	sie E	5+	ante	20		
Maryland	2 sho and is ma		19a. Informant's Name/Relationship (Typ		19b. Maili	ng Addres	s (Street and Numbe	er or Rural R	loute Number,	City or 1	Town, State, 2	Zip Code)	
	C = 14 F			iter)			cland Rd.						
Baltimore,	S to = 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	1 ,	Place of Dispo cometery, crea	osition (Na matory or	other place)	Date	9	20c. Loca	ation - City or	Town, State	
탪	permit. Page Depertment (Importent: If sny Injury or once.		4 □ Donation 5 □ Other (Specify)		eyland				2006	-au	Rel, M	10	
3al	permit. Pa Depertmen Importent: sny Injury once.		21. Signature of Funeral Service License		22	aughr	nd Address of Facility	Fune	eal svo	·_			
	40360		realight Concere SISI Batto What P. Ke, Battimore, MD 2										
			shock, or heart failure. List only one	ations that caused the deat e cause on each line.	n. Do not en	ter the mo	de of dying, such as	cardiac or re	espiratory arre	∍st,		Approximate Interval Between Onset and Death	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		nnection	re to	ssu disea	ise wit	th sclei	oder	ma	unknown	
1	Examiner			Due to (or as a conseq			•						
		10	Sequentially list conditions b.	Due o (or as a cons	4	pert	lusion	-				arkoom	
	uted Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200									
Ć	cate be executed physicien and the burial-transit	Exa	that initiated events c. resulting in death) Last	Due to (or as a conseq	uence of):								
8760,	ysicie	dical	d.										
68	uffica ng ph as th	Medi											
Вох	eath certific ettending p for use as	N/UR	23b. was decedent pregnant	c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta]Ectopic p	pregnancy			23	d. Date of deli		
Э.	The law requires that the death certific Ne hes been signed by the ettending p age 2 should be detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☑No	4☐Pregnant at time of d		Other (s					Month	Day Year	
P.0	at the de 1 by the stached	Ph.	9 Unknown				_						
Ś	res tha igned be del	ک	Part II. Other significant conditions conf	ributing to death but not res	ulting in the u	nderlying	cause given in Part I.					the cause of death?	
ord	w requir been si should	Completed						— I	1 16	s 2 🗆	No 3∏Pr	obably 4 2 Unknown	
ec	e law hes b	n pi	24a. Was an autopsy prior to cor									topsy findings available completion of cause of	
E		ပ်							perfórn 1 ☐ Yes 2		death? 1 🗌 Yes	2 No	
of Vital Records,	Physician: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	ospital:			1		check only on				
o	Phys this ral dii	5 7	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpatier 28b. Time o				5 Reside			cify)	
	ding P. After fune	ig G	1 ⊠Natural 5 ☐ Pending	(Month, Day Year)	Injury	' м	28c. Injury at Work? 1 ☐ Yes 2 ☐ N		. Describe no	w inquity t	occurred		
Si	or Attending siter death. Director: After in by the fune	lica	3 Suicide 6 Could not be	28e. Place of Injury - At he	ome farm str				Location (St	reet and i	Number or Ru	ral Route Number,	
Division	al or Attending F s efter death. I Director: After id in by the funera	Certification:	4 ☐ Homicide determined	building, etc. (Specif	y)	001, 14010	, omoo		City or Town	, State)		na riodio nambo,	
	To the Hospital of within 24 hours elemental Double funeral Doubletely filled in	edical (29a. Certifier 1 ☐ Certifying Physic (Check only one) 2 ☐ Medical Examin	cian: To the best of my kno er: On the basis of examina and manner stated.	wledge, deat ition and/or in	h occurred vestigatio	d at the time, date and n, in my opinion, deat	d place, and th occurred a	I due to the ca at the time, da	ause(s) ar	nd manner as lace, and due	stated. to the cause(s)	
	To the within 2 To the Complet	Me	29b. Signature and title of certifier			29	c. License number		25	9d. Date :	signed (Month	n. Day, Year)	
			Durtzon n	VP			000597	136		Octo	her 31	2006	
-	10		30. Name and address of person who cor	npleted cause of death (Iten	n 23a) (Type,	Print)		<u> </u>			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,	
	1		DEBORAH WATS	or m.D.	MOR	THWE	ST HOSPIT	AL	5401	040	Cou	RT ROAD	
	Sta Registi		31. Date filed (Month Day, Year) NOV 0 6 200	32 Registrar's Signa	Itôre	arts	,						

DHMH 17 Rev 1/2001

Registrar

2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)



6701

No Ch

29c. License number

Movember 2, 2006

Balto Md ZIZOX

		1	For State Registrer				nd / Dep	artment of h rtificate of	Health and	-		2006	35111
			I. Decedent's Name (Fil	rst, Middle, Las	t)					2. Date of D	eath		3. Time of Death
	/sician ledical		Ergin				Caglas	in		Novemb	er 4	ay Year 4 2006	8:00 P M
	amine		a. Facility Name (If not	institution, give	street and nun	nber)		4b. City, Town, o		ath	4	c. County of Death	
			Suburban F Social Security Numb			7 Ass //n	land historia	Bethesd		rs 0 Data at 0		Montgomer	
Fund Direct		1	None		ax Mim 2□F	7. Age (in yrs	i. last birthday Yrs.	Months Days		rs. 8. Date of 8 in. (Month, D	ay Year	1945 Til	place (State or Foreign intry) rkey
			Jsual Residence of Dec	edent						-F			
rylan	3			o. County			City, Town or L						10d. Inside City Limits
Ba-f		3		airfax		A	lexandı	ia			,		1 XYes 2 No
death with the Maryland me 23a or 28a-f show	Director of	5	10e. Street and Number					10f. Žip Code			10g. C	itizen of What Cou	intry?
eath v	in in	5	6562 Lockle	igh Cou	ırt 12. Was Dece	dent Ever in I	118 12	22315	diseasie Origin?	(Specify Vac or N		ırkey 14. Race - Amer	ican Indian
ē 2	it, the Medical Examiner count.	200	 Marital Status Never Married XX Widowed 4 □ 		Armed For 1 Tes If Yes, Giv Year or Da	rces? 2∑ No e	0.3.	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🛣 No		erto Rican, etc.)	10-	Black, White	
5-00 2 hou	ag la	3	15.	Decedent's Ed	ucation		16a. Dece	dent's Usual Occup	pation		16b. I	Kind of Business/li	
21215-0036 d within 72 hours atl giene.	Nation Nation	- 5	(Specify of Elementary/Secondar	nly highest gra- y (0-12)	de completed) College (1	-4or 5+)	life.	kind of work done DO NOT use retire	d) d)	vorking			
Market No.	- S	5 -			5+		<u> </u>	ngineer	1			onstructi	lon
vid be file Mentat Hy rked oth	5 0	2	17. Father's Name (First	•						lame (First, Middl		n Sumame)	
Dould Mer Amerika	i i	2 -	Galip Cagl 19a. Informant's Name/		Suna Print)		10h Mail	ng Address (Street		Caglasi		as Taura Chata 7	- O- d-1
Ma d2 sl d2 sl d2 sl d2 sl	tra u		Gul Dusi (- ' '	• • • • • • • • • • • • • • • • • • • •			Lockleigl			. ,		p Code)
be the should be the stand and Me the stand and Me the stand and me the stand me th	i i	9-	20a. Method of Dispositi		-1)	20b.	Place of Disp	osition (Name of		Date		ocation - City or T	own, State
Baltimol permit. Pages Department of Important: If it	7 9.		1 Burial 2 □Cr 4 □Donation 5 □			State		matory`or other pla metery	·	9/2006	Tzn	nir, Turk	ev.
altin Partmo	트	H	21. Signature of Funera			1 2.		2. Name and Addre			LDI	, 1011	
W Fag	any ii		1 Jena	10	Marie	11-		slamic Fu 51 Dekali			. NY	7 11205	
Physical Phy	le burial-transit		23a. Part1. Enter the dishock, or heart fai Immediate Cause (final disease or condition resulting in death) Sequentially list condition and the cause. Enter Underlyin Cause (Disease or injur that initiated events resulting in death) Last	ſ	a. Metasi Due to (Colon (pquence of):						Approximate Interval Between Onset and Death Years
O the d	ched yave		IF FEMALE: 23b. Was decedent pre- in the past 12 mon 1 Yes 2 No 9 Unknown	gnam ths?		irth 2 ☐ Fet ant at time of	tal death 3	□Ectopic pregnanc □ Other (specify) _	у			23d. Date of delive	rery Day Year
cords, P w requires that been signed b	š 3	: l'	Part II. Other significan	t conditions co	ontributing to de	ath but not re	esulting in the	inderlying cause giv	ven in Part I.		tobacco Yes 2		the cause of death? bably 4 Unknown
I Reco The law reate has bee	page 2						<u>-</u>			24a. Wa auto peri 1 🗆 Yes	opsy formed?	death?	opsy findings available ompletion of cause of
Vital Ficien: The certificate	actor.		25. Was case referred t examiner?	1	Linesiteli			100		eath (Check only	one)		
of Vital Physician: rthis certifica	a di		1 ☐ Yes 2X No 27. Manner of Death				ER/Outpatie		4 Mulsing			6 ☐Other (Speci	fy)
C 5 5	2 2		1 XNatural 5 2 ☐ Accident	☐ Pending investigation ☐ Could not be		of Injury h, Day Year)	28b. Time of Injury	M 1	ryat rk? Yes 2 ∐ No	28d. Describe		ury occurred and Number or Rur	
Div oital or A urs effer oref Direc	lled in by		4 Homicide	determined	buildir	ng, etc. (Spec	city)	reet, factory, office		City or To	own, Stat	te)	
DIVISIO To the Hospital or Attendit within 24 hours effer death. To the Funeral Director: A	Medical	2	(Check only 2 one)	Medical Exam	ysician: To the niner: On the ba and mann	asis of examin	nowledge, dea nation and/or in	h occurred at the til evestigation, in my o	opinion, death oc	ce, and due to the curred at the time	, date an	nd place, and due t	o the cause(s)
To	8		29b. Signatur and title	12	- WD			29c. Licens				ate signed (Month,	
. ~			20 Name and did	1 Com	nomoleted	o of door //-	m 22a\ /T	D29	0/3		NO	vember 5,	, 2006
4)			30. Name and address on Ralph Boco					Ledge Dr.	#4100 I	Bethesda	, Mai	ry1and	
	State		31. Date filed (Month, D	ay, Year)								·	
Re	gistrar		NO.	V 0 6 20	06	State .	B B	13/05					

EGAN LAMONT DAVIS, JR. 06-07698

Please Type or Print in Black Indelible Ink

JNK UNK		- For State tegistrar	State of	Maryla		•	nent of cate of	Health and Death	d Ment	al Hy	_	Reg. No. 2	nn	6 3511
Physician Medical Examine	1	Decedent's Name (First, Manager)		Λ λ.ε.Ο λτατ	T) A T/	TC	TD				2. Date of Dea Month	ath Day Y	'ear	3. Time of Death 1439 hrs
		EGAN 4a. Facility Name (if not institu	ition, give stre	AMONT eet and nun	DAV	12	JR.	b. City, Town, or		Death	October 1	4c. Count	,	h
Funeral		3801 Kenilworth Av 5. Social Security Number	enue 6. Sex	1	7. Age (In	vrs last b	oirthday)	Bladensburg		24Hrs	8 Date of Bi		Georg	e'S rthplace (State or Foreign
Director]	578-66-0318	1 XM		58	y10. 1401 b	Yrs	Months Days		Min.	JANUA	194	8 C	ountry WASHINGTO
any	-	Usual Residence of Decedent 10a. State 10b. Cour			1100	City Tou	n or Locati	on.		-				DC 10d Inside City Limits
*			NCE GEO	ORGE'				NSBURG						1 X Yes 2 No
the Maryland a or 28a-f show	3	10e, Street and Number						10f. Zip Code				10g. Citizen of	What Cou	intry?
r death with the Maryland or items 23a or 28a-f sho must be notified at once.	5	3801 KENILI		AVENUI Was Dece		05E	142 14/0	20710 s Decedent of His		-0/5	aif. Va. a. N	U.S.A.		
r death with or items 23	5	1 Never Married 2		Armed For				es, specify Cuban					ce - Amer nite, etc.	rican Indian, 8lack,
s after rall', o	5			es, Give Year Dates:				Yes 2 No			al. de ee	Specify	ות	LACK
5-0036 Howithin 72 hours after Hygiene. other than "natural", the Medical Examiner.	201	15. Decedent's Education (S Elementary/Secondary (0-1		College (1-		102	during me	ost of working life.	DO NOT u			16b. Kind of I		Industry
5-0036 iled within 7 Hygiene Jother than the Medica		12th					RETA	IL SALES					VATE	· ·
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ratt of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-fahr rother traumatic event, the Medical Examiner must be notified at once To Bo Completed by Elinoral Disorbor		17. Father's Name (First, Mide EGAN LAMONT		SR.]	VIVI			Maiden Surnan	ie)	
2121 should be fi nd Mental is is marked atic event,		19a. Informant's Name/Relation		Print)	-	1		Address (Street						
e, MD and 2 sho fealth and item 27 is traumati	+	ARLENE DAVIS				20b Place	e of Dispos	tion (Name of cen	TH AV	E. 1	505E Date	BLADEN:		G, MD 20710 Town, State
More Pages ent of F int: If		1 Burial 2 X Crema 4 Donation 5 Other	ion 3 R	Removal fro			atory or oth	er place) CREMATO	RY	10-2	252006	RIVER	DALE	, MARYLAND
Baltimore, MD 21215 permit Pages I and 2 should be file Department of Health and Memal H Important: If item 27 is marked injury or other traumatic event, th		21. Signature of Funeral Serv		00	1		. 22. N	ame and Address	of Facility	J.	B. JEN	KINS F	UNER	AL HOME
Physician	+	23a. Part I. Enter the disea	or complicati	ons that ca	used the d	eath. Do	74 not enter th	74 LANDO se mode of dying,	VER R such as ca	OAD rdiac or	LANDO\ respiratory arr	ER, MAR	YLANI neart	20785 Approximate Interval
/Medical Examiner		failure. List only one िक्य Immediate Cause (Final disea	ise a. I	ne. Diabeti	ic keta	oacido	osis							Between Onset and Death
	1													
Sit of														
60, ite be executed by sician and e burial - transit	5 -	WNPENDED	dAM	MENDED				NE 044 4	4 /0 /04					
760, icate be physici the buri		F FEMALE: 3b. Was decedent pregnant in	25 25	Bc. If yes, o	tem#2 utcome of	bregnanc	L,2/,De	erME,g861,1	.1/9/06 _	TT		23d. Date	of deliver	y
Box 6876 e death certificat the attending phy ed for use as the		past 12 months?	4	Live bir	th int at time	of death		aldeath 3 ner (Specify)	Ectopic	pregnan	су	Month	1	Day Year
D. Bo trithe deat by the at ached for	ÈL	1 Yes 2 No 9 Part II. Other significant con	Jnknown 9			not result			ivon in Bod		23a Didti	abassa usa san	tributo to	the cause of death?
P.O. es that iigned b	3	Atherosclerot						nderlying cause g	iven in Fan	. 1.				bably 4 Unknown
Records, The law requires ficate has been sig	200								-		24a. Was			utopsy findings available completion of cause of
Rec(The laricate hat page 2											perfo 1 V Yes	rmed? 2 No	death?	es 2 No
Vital Recysician: The his certificate director, page	3 ·	25. Was case referred to med examiner?	Hospi	tal: 1 n	patient 2	ER/	Outpatient		of Death (C		Home 5	Residence 6	Othe	r Scene
of \oldsymbol{Of} Of \alpha ing Phy	The second of th													
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atherosclerotic cardiovascular disease Atherosclerotic cardiovascular disease								Stroot and blum	hor or D	real Double Number City				
Divi			ould not be etermined	(Specify)	or injury -	At Home,	iaini, stree	it, factory, office bi	anding, etc.		or Town, S		Del Ol Ku	arai Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitional Certification: To Be Completed by Divisional Modical Examples of the property of the pure as the burial - transitional Certification: To Be Completed by Divisional Modical Examples of the property of the pure attention o		29a Certifier 1 Certifying (Check only 2 Medical E	xaminer:On t	the basis of	examinati	wledge, d ion and/o	leath occuri r investigati	red at the time, da on, in my opinion,	te and place death occu	e, and durred at	lue to the caus the time, date	se(s) and mann and place, and	er as star due to th	ted. ne cause(s)
F 3 5 8		29b. Signature and title of cer	ufier () 1	manner sta	ated	_		29c. License	number			29d. Date sig	ned (Mo	nth, Day, Year)
		Torsho		>0X	211)		O.C.N	Л.Е. 			October 1	4, 200	6
	1	30. Name and address of pers Tasha Greenberg N		stant Me	dical Ex	kamine	r 111	Penn Street, I	Baltimore	e, MD	21201			
Stat	e	31. Date filed (Month, Pay Ye	y 6 200	6 32. Ref	istrar's Sig	gnature	e A	will .						
Registra	11				L'action and any	03/40/	E STATE OF THE PARTY OF THE PAR							

			For State	State of Ma	aryland	d / Depa	artment of I rtificate of	Health a	and M	ental Hy	giene	2008	35	113
	-	-0	Registrar 1. Decedent's Name (First, Middle, L	ast)		061	tineate or	Death	-	2. Date of De	Reg. No.		3. Time of	Death
	Physici		Edythe M. Dierke	r						Month October	Day • 3∏	2006		3 P M
1	/Medic Examin		4a. Facility Name (If not institution, g				4b. City, Town, o	or Location of				County of Dea		<u>, L</u>
e de la companya de l			Gilchrist Center				Towson					ltimore		
в	Funeral		ľ	Sex 7. Ag		a <i>st birthd</i> ay) Yrs.	If Under 1 Year Months Days	If Under:	24 Hrs. Min.	8. Date of Bir (Month, Da	y, Year)	9. Bir	thplace (State o	r Foreign
Ba	Director		174-20-3124 Usual Residence of Decedent		81	-				09/06/	1925	Per	nsylvar	nia
	yland now at		10a. State 10b. County		10c. City	, Town or Lo	ocation						10d. Inside Ci	ty Limits
	e Mar la-f st tiffied	ctor	Maryland Baltin	ore	Tim	onium							1 □Yes	² ₩No
	or 28	Dire	10e. Street and Number				10f. Zip Code				10g. Citiz	en of What C	ountry?	
	s 23a	Funeral Director	226 Deep Pale Dr		II 6		21093					.S.A.		
	item Item	Į.	11. Marital Status 1 □ Never Married 2X Married	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 🔀 !			Was Decedent of I If Yes, specify Cub	Hispanic Ori ean, Mexican	gin? (Spe i, Puerto F	cify Yes or No Rican, etc.)	· 1	 Race - Ame Black, Whi 		
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ther, the Medical Examiner must be notified at	ρ	3 ☐Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	••		1 ☐ Yes 2 ☐ No	Specify:				Specify: யி	nite	
2-0	72 ho natur lical E	Completed	15. Decedent's (Specify only highest of	Education		16a. Dece	dent's Usual Occu kind of work done	pation	t of workir	ng.	16b. Kin	d of Business	/Industry	
21	ithin 7 ne. nan "i	nple	Elementary/Secondary (0-12)	College (1-4or 5	i+)	life.	DO NOT use retire	danny mosi d)	O WOIKII	ig .				
	fygier her th		12 17. Father's Name (First, Middle, La	-0		Secre	etary	10 14-15-	NI	/Final Adidate		teel Ir	ndustry	
Maryland	ould be fi Mental H arked ot atic ever	Be	, , , , ,	,						(First, Middle,		Surname)		
Ž	should Ind Men marke	P	Henry G. Studer 19a. Informant's Name/Relationship			19b. Mailir	ng Address (Street			Dripps		Town State	Zin Code)	
Ma	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Milton Dierker, H	, ,			eep Pale					21093		
J.	es 1 and 2 of Health Item 27 I		20a. Method of Disposition		20b. Pla	ace of Dispo	sition (Name of matory or other pla	- ;		ate		ation - City or		
<u><u>E</u></u>	Page nent ant: If ury o		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		Hil	ltop S	ervices	1	11/01	/2006	Tows	son, Ma	aryland	
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Meone.		21. Signature of Funer & Service Up	ense		1.5	2. Name and Addre	ess of Facilit	y RUck	. Towso	n Fur	neral H	Home, In	ıc.
			23a. Part1. Enter the disease, or co	mplications that caused	the death.							204	Approximate	е
	Physician	8: 7	shock, or heart failure. List only one cluse on each line. Interval Between Onset and Death											Death
4	/Medical		disease or condition resulting in death)	Due to (or as								-	Zwee	2 4
ь	Examiner		Sequentially list conditions											
	pa tis	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequ	ence of):								
	ecute and I-trans	xam	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consenu	ence of):		_						
68760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	E E		200 10 (0. 00	a consequ	01100 017.								
687	ificate g phys	edical		d										
Вох	death certific attending pl d for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			75				2	3d. Date of de	livery	
	deat e atte	sicia	in the past 12 months? 1 ☐ Yes 2 M No	4□Pregnant at			□Ectopic pregnand □Other (specify) _	У				Month	Day Y	Year
P.0	at the de d by the a stached	Phy	9 Unknown											
	res tha signed be det	þ	Part II. Other significant conditions Rheume to a	Contributing to death bi	ut not resul	Iting in the u	nderlying cause giv	ven in Part I.					o the cause of d robably 4 □L	
Records,	w require been sig should b	Completed	due to ale		. , , ,	1		7	,	-			—————	JIKHOWII
3ec	has the 2 s	mple	- to can	in cest a	9e/	CE	raic :)acl		24a. Was autop	an osy rmed?	24b. Were a prior to death?	utopsy findings a completion of ca	available ause of
Vital	iclan: The l certificate ha ector, page		25. Was case referred to medical	1						1∐ Yes	2 □ No	1 ☐ Yes	2 □ No	
⋚	ysiclan; is certific director,	o Be	examiner?	Hospital:	nt 2 TF	B/Outpatier	nt 3 DOA Oth			(Check only o		Π α (0	city) Herso	. (
O.	g Phy er this eral c		27. Manner of Death	28a. Date of Inju	ry	28b. Time o				8d. Describe I			city) / / - /-	
io	Attending F r death. ector: After by the funer	atio	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigati		rear)	Injury		rk? Yes 2∐1	Vo OV					
Division	r Atte	Certification:	3 Suicide 6 Could not 4 Homicide determine		ry - At hor c. (Specify)	ne, farm, str	eet, factory, office		2	8f. Location (5 City or Tox	Street and vn, State)	Number or R	ural Route Num	ber,
	oital o urs aff eral D								- 1					1
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: / completely filled in by the fi	Medical	29a. Certifier 1 ☐ Certifying I (Check only one) 2 ☐ Medical Ex	Physician: To the best of aminer: On the basis of and manner sta	examinati	vledge, deat ion and/or in	h occurred at the ti vestigation, in my	me, date an opinion, dea	d place, a th occurre	nd due to the ed at the time,	cause(s) a date and	and manner a place, and du	s stated. e to the cause(s	.)
	To the within To the complex c	×	29b. Signature and title of certifier				29c. Licens				29d. Date	signed (Mon	th, Day, Year)	
	1		13/20	mar	4		0	247	132		/	0/31/	06	
	10		30. Name arld address of person wh	o completed cause of d	eath (Item	23a) (Type,	Print)	0 72	ر ب	0-1	NB	2/2	04	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	ar's Signat	ure	1 4	- (
	Registr	State egistrar NOV 0 6 2006 32. Registrar's Signature												

		1	State of Maryland / Department of Health and Me 1- For Registramend #20c Per FH G861 11/06/Oertificate of Death	ental Hygiene Reg. No	CULID	35114
	Physicia	n		2. Date of Death	200 gar	3. Time of Death 3. A M
	/Medic Examin		4a. Eacility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALLIMORE	40	c. County of Death	
	Funeral Director			B Date of Birth Monty Day Year	938 MA	ace (State or Forbign
	aryland ahow dat		Usual Residence of Decedent 10a. State 10b, County 10c. City, Town or Location		10	0d. Inside City Limits :
	death with the Maryland ms 23a or 28a-f ahow	by Funeral Director	10e. Street and Number NINPMK ("ON F ARE 2.12.3.7	10g. C	itizen of What Coun	try?
	er death v	unerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 2 6	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White	
-0036	within 72 hours after ene. than "natural", or ite he Medical Exelicity	ed by F	3 Widowed Divorced If Yes, Give Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation	\2	Specify: D	HCA Sustry
21215-0036	filed within 72 Hygiene. other than "na ent, the Juedia	Completed	Elementary/Fecondary (0-12) College (1-4or 5+) College (1-4or 5+)	3	Choo!	,9
Maryland	buld be filed Mental Hygis arked other atic avent, I	To Be C	17. Father's Name (First, Middle, last) 18. Mother's Name 10. A	(First, Middle, Maide	en Sumanle)	Albite
	s 1 and 2 should be filed within 72 hours after death with the Marylan I Heath and Mental Hygiene the state of thems 23a or 28a-f ahow item 27 is marked other than "natural", or items 20a or 28a-f ahow other traumatic avent, if a Medical Eraphinar must be notified at		ERICA: DOUGLASS, Se (30N) 5-3/2) DAY DEOOK	l Proute Nymber, City	Cocation - City or To	2 MACSH
Baltimore			20a. Method of Disposition 1 Sourial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	1 2001	altimore,	
Balt	permit. Page Department of Important: if eny injury or once.		21. Signafure of Funeral Service Licenses 1 22. Name and Address of Facility 10 1342 N CHURCH	AVE. BA	HOIND. Z	1202
3	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	respiratory arrest,		Approximate Interval Between Onset and Death
*	/Medical Examiner		Due to (or as a consequence of):	78#		
	acuted ind transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):			
8760,	cate be executed obysician and the burial-transit	dicai	d			
.O. Box 6	ath certifi attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown		23d. Date of deliv Month	ery Day Year
4	ires that the de signed by the d be detached				co use contribute to t	
I Records,	The law requirate has been sipage 2 should I	Completed by		24a. Was an autopsy performed 1 Yes 2 3	? prior to co	opsy findings available impletion of cause of
of Vital	ding Physician: The lav h. After this certificate has funeral director, page 2	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	me 5 Residence		go Living
sion o	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Diractor: After the completely filled in by the funera	Certification;	27. Mann of Death 1 Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Injury M 1 Yes 2 No	28d. Describe how in 28f. Location (Street		al Boute Number
Division	tal or Atters at Diracters birdings by the	Certific	3 Suicide 4 Homicide 3 Suicide 4 Homicide 4 Suicide 5 Suicide 6 Suicide 8 Suicide	City or Town, Si	tate)	
	ne Hospi n 24 hou ne Funer oletely fill	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, considerable of the construction of	red at the time, date	and place, and due	O IIIe Cause(s)
	To the To the Complex	Σ	29b. Signature and title of certifier 29c. License number 29c. License number 29c. 11 48	1	11-3-06	Jay, rear)
	たり		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DONATO A VARCEAS - 1 12 4700 HARTEND RODD BATTIMONE, MCTYLUN 212	14		
	S Regis	tate trar	31. Date filed (Month, Day, Year) 32. Registrar's Signature			

State of Maryland / Department of Health and Mental Hygieney 2006 Certificate of Death Reg. No. 1. Decedent's Name (First Middle Last) 2. Date of Deeth 3. Time of Death Year **Physician** EDITH R. EDWARDS 31 205 AM 06 10 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner AUGSBURG LUTHERAN HOME & VILLAGE GWYNN OAK BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 04/23/1907 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) **Funeral** Days 1 M 200 F 218-01-4172 99 Yrs. Director MARYLAND Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylend Department of Health and Mentel Hygiene.
Important: If Ifem 27 is marked other than "nature" any injury or other traumatic excessions. 10a. State 10c. City, Town or Location 10d. Inside City Limits MD BALTIMORE GWYNN OAK 1 ☐ Yes AFTNo Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 6811 CAMPFIELD ROAD 21207 USA Funerai Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: BLACK Be Completed by XXWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12TH HOUSEKEEPER DOMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JAMES SKINNER MAMIE ROBERTS 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 21207 MILDRED L. EDWARDS / DAUGHTER 3510 FOREST HILL RD., BALTIMORE, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ARBUTUS MEM. PARK 11/04/06 BALTIMORE CO, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD ter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heer failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical . END STAGE ALZHETMER DEMENTIA Examiner Due to (or as a consequence of): Physician/Medical Examiner ed by the ettending physician and detached for use es the bunal-transit Attending Physician: The lew requires that the death certificeta be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? To the Hospital or Attending Physician: The lew requires that the within 24 hours efter death.

To the Funeral Director: After this certificate has been signed by completally filled in by the funeral director, pega 2 should be defacted. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 12 Unknown 2 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 PNo 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a Date of Injury (Month, Dey Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) H45931 November 1 2006 who completed cause of death (Item 23e) (Type, Print) Avenue Baltimore MD 21208 7220 HOUR HEIGH Is 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State Coste NOV 0 6 2006 Registrar

6:03 AM

10d. Inside City Limits

Approximate Interval Between Onset and Death

moutes

White

Witz

1 ☐ Yes 2 No

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 ☐ Yes 2 ☐ No 1□ Yes 2 No

October 31, 2006

Day

25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 1 Natural

5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and flue to the nause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

RES-000 cause of death (Item 23a) (Type, Print)

32. Register's Signature

4940 Eastern Are Baltimore, MD 21224 DR. Jeneen M. Gifford

State Registrar

Be

2

Certification:

Medical

31. Date filed (Month, Day, Year)

NOV 0

2006

this is

death.

within 24 hours a

To the Funeral Director: After th completely filled in by the funeral

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav **Physician** GLORIA J. FLOYD 2 2006 Ovember /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner kn Burnie Vedical Center timore Washington 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Washington D.C. Social Security Number If Under 1 Year If Under 24 Hrs **Funeral** 1 M 2 F Months Days 579-40-1638 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 No Director Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or ed other than "natural", or Items 23a or event, the Medical Examiner must be 21122 U.S.A. 8408 A. Garland Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: and 2 should be filed within 72 hours after 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🗹 No White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene, Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (Department of Health and Mental Important; If Item 27 Is marked o any Injury or other traumatic eve once. Unkown Chauncey Blaine 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8408 A. Garland Road, Pasadena, Maryland 21122 Robert Floyd Sr. (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Cedar Hill Cem/ 11-7-06 Brooklyn Park, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerall Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 23a. | art1. Enter the disease, or com. loations that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause, neach line. such as outdiac or respiratory arrest Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical us to (or as a consequence of) Examiner ear Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or as a consequence of Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 □ Yes ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 2 NO 1 ☐ Yes 1□ Yes To the Hospital or Attending Physiclan: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 ☐ No Hospital: 1 🗌 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

Mudva

lu

who completed cause of death (Hem 23a) (Type, Print)

32. Registrar's Signature

2.13.1

or baty mo

6 2006

0

			1 - State of Mary	•	artment of He tificate of D			ene 006	35118
, y.	Physici	an	1. Decedent's Name (First, Middle, Last)				Date of Death Month	Day Year	3. Time of Death
1000	/Medic	al	4a. Facility Name (If not institution, give street and number)		4b. City. Town, or	Location of Death	10 3	4c. County of Dea	, 1105 PM
200	Examin	er	9302 EDWAY CIRCLE		RANDAUS			BALTIMOR	
46.5 K	Funeral Director		5. Social Security Number 6. Sex 7. Age (In 2 F 80	yrs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, 01-24-10	Year) 9. Bin Co	hplace (State or Foreign nuntry) MD
	land ow	}	Usual Residence of Decedent 10a, State 10b, County 10c	c. City, Town or Loc	cation				10d. Inside City Limits
	a-fsh	ctor	MD NA B	ALTIMORE					1 @Yes 2 ☐ No
	death with the Maryland ms 23a or 28a-f show rinust be notified at	Director	10e. Street and Number		10f. Zip Code 2122	7	10	g. Citizen of What Co	ountry?
	death ms 23	Funerai	1921 NORTHEAST AVENUE 11. Marital Status 12. Was Decedent Ever		Vas Decedent of His	spanic Origin? (Spe	cify Yes or No-	USA 14. Race - Ame	
920	be filed within 72 hours after death with the Marylar at all typiane. I at Hygiene. I at Hygiene. I at Hygiene. I at the Maryleal Exacitizational be notified at event, the Maryleal Exacitizational beauty.	þ	Amed Forces? 1 Never Married 2 Married 1 Yes 2 M No 3 Widowed 4 Divorced Year or Dates:		f Yes, specify Cuban	Specify:	Rican, etc.)	Specify: BL	e, etc. ACK
- 2	72 ho	eted	15. Decedent's Education (Specify only highest grade completed)	(Give)	lent's Usuaf Occupa kind of work done do	uring most of working	19	6b. Kind of Business	
Maryland 21215-0036	filed within Hygiene. other than '	Completed	Elementary/Secondary (0-12) 12 TH GRADE College (1-4or 5+)	SELF	OO NOT use retired) EMPLOYE	D		AUTO DETA	IL
and		Be	17. Father's Name (First, Middle, Last) JAMES ALEXANDER			18. Mother's Name HELEN 11	_	aiden Sumame)	
ary	s 1 and 2 should it Health and Men item 27 is marke other traumatic	To	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin				City or Town, State,	Zip Code)
	and 2 ealth a m 27 is		SHEILA BARNES (DAUGHTER	and the latest and th	WABASH			MD 21215	
more,	Pages 1 all nent of Hea int: If item iry or othe		1 M Burial 2 Cramation 3 Removal from State		sition (Name of natory or other place)		0c. Location - City or	
altin	permit. Pages Department of Important: If i any injury or once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Fungeral Service Lice Specify	ARBUTUS	Name and Address	II- 06		BALTO. MO	
m	F F F S		Naughn C I	51	51 BAUD. 1	VATE PIKE,	BAUTO.	MD 21220	
			23a. Part1. Enter he disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final					st,	Approximate Interval Between Onset and Death
	/Medical		disease or condition resufting in death) a		ECTAL	CANCER			1 MONTH
	Examiner		Sequentially list conditions, b	0					
	uted 1 ansit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	nsequence or):					
oʻ	ate be executed hysician and the burial-transit	Еха	resulting in death) Last Due to (or as a con	nsequence of):					
	ate the	dicai	d						
9 xo	death certific e attending p od for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □		15			23d. Date of de	ivery
O. B	at the death by the atte	Physician/Me	in the past 12 months? 1 Yes 2 No 9 Unknown 1 Unknown		Ectopic pregnancy Other <i>(specify)</i>			Month	Day Year
۳.	requires that the reen signed by th hould be detache	by Ph	Part If, Other significant conditions contributing to death but no	nt resulting in the ur	nderlying cause give	n in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ords	w require been sig should b						1 🗆 Yes	2 □ No 3 □ P1	obably 4 POnknown
Vital Records,	e law has b	Completed					24a. Was an autopsy perform	ed? prior to death?	utopsy findings available completion of cause of
a	icien: Th certificate ector, pag	BeCc	25. Was case referred to medical			26. Place of Death		Vo 1 ☐ Yes	2 No
<u>و</u> <	Physicien: this certifice al director, p	၉		2 ER/Outpatient		4 Nursing Hon		nce 6 Other (Spe	cify)
O	ling After funer	tion:	27. Manner of Death 1 Natural 5 Pending 2 Accident Accident Accident 28a. Date of Injury (Month, Day Yea	ar) 28b. Time of Injury	Work	at ? 'es 2 □No	8d. Describe hov	v injury occurred	
Division of	I or Attendi after death. Director: A I in by the fu	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of fnjury - building, etc. (Si	At home, farm, stre pecify)	eet, factory, office	2	8f. Location (Stre City or Town,	eet and Number or Ri State)	ural Route Number,
	ospitel hours unerel ly filled		29a. Certifier (Check only) 1 Certifying Physician: To the best of my 2 Medical Examiner: On the pass of exa	y knowledge, death	occurred at the time	e, date and place, a	nd due to the cau	use(s) and manner as	stated.
	To the H within 24 To the Fi complete	Medical	29b. Signature and title of certifier	THE RECORD AND STORY	29c. License			d. Date signed (Mont	
)	¥ ¥ € 8		rellrah steene						
	H		30. Name and address of person who completed cause of death	(Item 23a) (Type,	Print)	A	On ==	1005 -	1 2006
(2.2	Sta	te	31. Date filed (Month, Ray, Year) 2006 32. Registrar's 5) PAICIC Signature A	HEIGHTS I	HVENUE	ISHL(IN	NOILE 2	1608
* *	Registi		NUV O 6 ZOU6	15 19					

06-08076 Robert Hunt

Please Type or Print in Black Indelible Ink

tobert Hunt		State of Maryland / Department of Health and Mental Higher State 1. For State Certificate of Death Registrar	R	eg. No 2006	3512					
Physicia Medical Examin		1. Decedent's Name (First, Middle,Last) ROBERT E. HUNT	Date of Dea Month October 2	Day Year 27, 2006	3. Time of Death 0500 hrs					
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 1923 East Hoffman Street Baltimore		4c. County of Death						
Funeral	4	5. Social Security Number 6. Sex 7. Age (in yrs. last birthday) If Under 1 Year If Under 24Hrs	8. Date of Bi	rth(MM/DD/YYYY) 9. Birth						
Director		216-42-9864 1XM 2F 62 Yrs Months Days Hours Min.		14/1944 Foreign Cour						
v any	-	10a. State 10b. County 10c. City, Town or Location	,		10d. Inside City Limits					
Maryland 28a-f show datonce.	ġ.	MD BALTIMORE 10e. Street and Number 10f. Zip Code	14	Og. Citizen of What Count	1 X Yes 2 No					
ith the Maryland 23a or 28a-f sho	Director	1807 N. MILTON AVE. 21213		USA	,					
15-0036 filed within 72 hours after death with the Maryland I Hygiene. d other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once	L	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specific Cubes Mayison Photos			an Indian, Black,					
ter death		1 Yes 2 X No 3 Wildowed 4 YDivorced If Yes, Give Year 1 Yes 2 X No		Specify BLA	אר					
ours afi atural' xamine	항	15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of warring life. DO NOT use retired to the property of the propert		16b. Kind of Business/In						
5-0036 led within 72 hours after thygiene. In other than "natural", the Medical Examine.	Completed by	Elementary/Secondary (0-12) College (1-4 or 5+)	,	ROADS						
5-003 iled withi Hygiene. Jother th			e (First, Middle,	Maiden Surname)						
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than cevent, the Medica	To Be	WILLIE L. HUNT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or F	FALLS Rural Route Nui	mber, City or Town, State,	Zip Code)					
e, MD 21 I and 2 should I Health and Mer Titem 27 is mar		THELMA TILLER 1807 N. MILTON AVE.,		MORE, MD 212	213					
imore, MD 2121 Pages I and 2 should be filment of Health and Mental tant: If item 27 is marked or other traumatic event,		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or T 5500 O'Doni						
Baltimore, pernit. Pages I an Department of Hea Important: If iter	1		/31/06	BALTIMORE,						
Ba perm Depa injiri	1	Allhar Mun 2007-09 EASTERN	AVE F	HAVIS, JR. FI BALTIMORE, MI	21231					
Physician /Medical	Approximately ap									
Examiner		Immediate Cause (Final disease or condition resulting in death) Thermal injuries Due to (or as a consequence of):			Death					
	<u></u>	Sequentially list conditions, b								
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated								
cuted nd transit	EX	events resulting in death). East								
60, ate be exe hysician a	edica	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy								
iox 68760, eath certificate be executed attending physician and for use as the burial - transi	an/M	FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	ancy	23d Date of delivery Month Da	y Year					
Box 687 death certific the attending ped for use as the	Physician/	4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown		1						
that the d	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I		obacco use contribute to the						
IS, P quires then en signer			24a Was	an 24b. Were auto	opsy findings available					
cords, e law requir e has been s	Completed		auto perfo 1 ✔ Yes	ormed? death?	mpletion of cause of					
tal Rection: The certificate ector, page	Be Co	25. Was case referred to medical 26 Place of Death (Check		2 No 1 Yes	2 140					
of Vita	To B	1 V Yes 2 No 1	ng Home 5	Residence 6 Other:	Scene					
Division of Vital Records, P.O. pital or Attending Physician: The law requires that th ours after death reral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach	ij	1 Natural 5 Pending Oct 27, 2006 0407 hrs 1 Yes 2 ✔ No		ired in house fire						
ivision or Attendather death Director:	Certification:	2 M Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	or Town	Street and Number or Rura State)						
ospital hours a inneral		4 Homicide determined (Specify) Sidewalk 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and		Hoffman Street, Balt						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Finneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial – transit	Medical	(Check only one) 2 Medical Examiner: On the best of my knowledge, death occurred at the linie, date and piece, and and manner stated.	at the time, date	and place, and due to the	cause(s)					
F 3 F 3	Me	29b. Signature and title of certifier 29c. License number O.C.M.E.		29d. Date signed (Mont October 27, 2006	h, Day, Year)					
		30. Name and address of person who completed cause of death (Item 23a)		50,000, 27, 2000						
		Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21	1201		:					
St Regist	ate rar		_							

State of Maryland / Department of Health and Mental Hygiene UU6 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 19.35 M 2006 Hawkes Sr. Ernie /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore SAMAITAN HOSDITON 6000 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours **™** 2□ F VA 36 Director 214-08-8841 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County r than "naturel", or iteme 23s or 28a-f ehow the Medical Examinar must be notified at 1 X Yes 2 ☐ No Baltimore NA MD **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21206 5809 Waycross Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: Black þ 3 Widowed 4 Divorced Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th grade College (1-4or 5+) Black & Decker Co. Tool Technician nă other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Deperment of Health and Mental Hy Important: If Item 27 is marked other any injury or other traumatic event QME8. Theresa Hawkes Ralph Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5809 Waycross Road, Baltimore, Md 21206 Kim Hawkes-Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 11/4/06 Randallstown, Md 22. Name and Address of Facility
March F/H West 21. Signature of Funeral Service Licensee 21215 4300 Wabash Ave, Baltimore, Md Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic Privsician /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner end Due to (or as a consequence of): attending physicien e for use as the burial-Box 68760, Physician/Medical (he use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? Month Day Year detached for 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 X No 1 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA 1 🗌 Yes 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospitel or Attending Pl within 24 hours after death. To the Funerel Director: After th completely filled in by the funera 27. Manner of Death Certification: After Natural Accident 5 Pending 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide 1 Contriving Physician: To the best of my knowledge death occurred at the time date and date and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation in my opinion 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier MD Keg 000 11/1/2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 Lack Raven Blood, Baltimore, MD, 21239 Sourdaluitski, Dmitri 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 0 6 2006

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiena Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) $^{\text{Day}}$ 3, 2006November D **Physician** Mary M. Horman 11:30am M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 3913 Franklinville Road New Windsor Carrol1 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 1 □ M 2 1 F Yrs. Director 216-12-7680 90 July 8, 1916 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or items 23a or 28e-f show the Medical Examiner must be notified at MD Carroll New Windsor 1 Yes 2 No Director 10e. Street and Number 3913 Franklinville Road 10g. Citizen of Whal Country? 10f. Zin Code 21776 USA death y by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours efter 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3√ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry marked other than Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental H tent: If Item 27 Is marked other George C. Black Ivy Fritz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Rhonda Zile (Granddaughter) 3913 Franklinville Road New Windsor, MD 21776 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Importent: If any injury or once. injury or Lake View Mem. Park 11/7/2006 Sykesville, MD ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee HAIGHT TINERAL HOME & CHAPEL, PA (Box 195) Sykesville, ND 21764 (410)-795-1400 Blia 23a. Part 1. Enter the disease, or complications had caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caused the death of the displacement of the displacem Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Oskarung PRIMale 2 WKS **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or se a consequence of) Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician by Physician/Medical the as esn IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy ξ in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 10 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed? 1 ☐ Yes 2 19 No 1 Tes 2 3 N Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 2 3□ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: al or Attending P s after death. I Director: After After 1 5 Pending 1 Matural investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours To the Funerel 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of ceptifier 29d. Date signed (Month, Day, Year) 2 11/3/06 30. Name an var ress of person who completed cause of death (Item 23a) (Type, Print) 1000 LIBERTY, URINS THERICK SUITE 102 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 6 2006 Registrar

			For State Registrar	State of Marylan		artment of H rtificate of I			2008	35124
	Dhysisi	~-	1. Decedent's Name (First, Middle, Last	. 1	-			2. Date of Death Month	Day Yea	3. Time of Death
	Physici /Medio		EMERSON L	- HOLLAN	Δ,			11	02 0	6 10:22a M
	Examir	er	4a. Facility Name (If not institution, give 916 Copley Aven			4b. City, Town, or Waldorf	Location of Death		4c. County of De Charles	eath
	Funeral Director		5. Social Security Number 218-28-7145 6. Se	x 7. Age (In yrs. 74	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y Jan 25 1	^(ear) 9. E 932 M	Birthplace (State or Foreign Country) D
	pur *		Usual Residence of Decedent 10a, State 10b, County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	Maryli	tor	Md Charle	s W	aldorf					1 ☐ Yes 2X No
	th with the 23a or 284 at Le not	al Director	10e. Street and Number 916 Copley Avenue			10f. Zip Code 20602		100	J. Citizen of What USA	Country?
980	pernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: if Item 27 is marked other then "naturel", or Items 23a or 28a-1 show any njury or other traumatic event, Ita Modical Exactly at Intest be notified at ODGs.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒Divorced	12. Was Decedent Ever in U Armed Forces? ↑♥☐ Yes 2 ☐ No If Yes, Give Viet Year or Dates:	1:	Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 ☐XNo	spanic Origin? (Sp n, Mexican, Puerto Specity:	pecify Yes or No- Rican, etc.)	14. Race · Ar Black, W Specify: b	
5-0	72 hc	etec	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual Occupa	furina most of wor	king 16	b. Kind of Busines	ss/Industry
21215-0036	within jiene. r then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired tary serv		A	ir Force	
	ild be filed lental Hyg ked othe Ic event,	To Be C	17. Father's Name (First, Middle, Last) John Wesley Holla	and			18. Mother's Nam Agnes O	e (First, Middle, Ma • Smith	iden Sumame)	
Maryland	nd 2 shou Bith and M 27 is mai		19a. Informant's Name/Relationship (T) Josephine Dotson (ra <i>l R</i> oute <i>Number, C</i> 1timore,		e, Zip Code)
Baltimore,	Pages 1 a nent of He int: If Item iry or othe	1,3	20a. Method of Disposition 1	Removal from State	emetery, cren	sition (Name of natory or other place Forest Ve	9)		ings Mil	
Balti	permit. Departmine imports any nite		21. Signature of Funeral Service Licens Parak Daugust C	al Home 21784	& ChapeI					
	Physician		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	l,	Approximate Interval Between Onset and Death					
ı	/Medical Examiner	3-	Supportially list conditions	Due to (or as a conseq ADRTIC Due to (or as a conseq	Dis	SECTI	D~			445
	acuted Ind transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	HIPERTE	NS/D	2				yrs.
58760,	icate be executed physicien and s the burial-transit	dical E		Due to (or as a conseq	uence or):					
P.O. Box 6	ath certification or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3□	Ectopic pregnancy Other (specify)			23d. Date of d Month	delivery Day Year
	quires that the de n signed by the a uld be detached f	by	Part II. Other significant conditions co	ntributing to death but not res	ulting in the ur	nderlying cause give	on in Part I.	23e. Did toba		to the cause of death? Probably 4 Unknown
Division of Vital Records,	he law requir e has been si age 2 should l	Completed						24a. Was an autopsy performe	d? prior to	autopsy findings available o completion of cause of ?
a		0	25. Was case referred to medical				26. Place of Dear	h (Check only one)	No 1 1 Y	es 2/XNo
>	hysici nis ce I direc	To B	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	t 3 DOA Othe	er: 4 🗌 Nursing Ho	ome 5 Residence	e 6 ∐Other (Sp	pecify)
ono	ding Physician: The lav h. After this certificate has funeral director, page 2	tlon:	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work	at ? ∕es 2 □No	28d. Describe how	injury occurred	
Divisi	Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica itiely filled in by the funeral director.	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify				28f. Location (Stree City or Town, S	et and Number or . State)	Rural Route Number,
_	To the Hospital within 24 hours a within 24 hours a To the Funeral completely filled	Medical C	29a. Certifier Contifying Phy (Check only one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the tim restigation, in my op	e, date and place, inion, death occur	and due to the caus red at the time, date	se(s) and manner and place, and d	as stated. ue to the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier	4. Srin	al Box	29c. License	0046345	29d	Date signed (Mo	nth, Day, Year)
	101		30. Name and address of personno co				MAORF	MD 206	-1	
100	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 6 200	36600 LEO NA 32 Registrar's Signa	ture	ale)				

		1 - For Stete Registrer	State of Marylan		artment of H			giene Reg. No.	06	35125
Physici	an	1. Decedent's Name (First, Middle, Last) JAME			HUN	7	2. Date of De Month	Day	Year	3. Time of Death
/Medic Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Dea	NOVEM	4c. County	y of Death	6.73 4
Funeral Director		5. Social Security Number 6. Sep 216-34-8594 12 Usual Residence of Decedent		last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Da	10 10 10 10 10 10 10 10 10 10 10 10 10 1	9. Birthp Coun	elace (State or Foreign etry)
he Maryland 28e-f show pilified at	Director	10a. State 10b. County 10e. Street and Number		y, Town or Lo	Re_					0d. Inside City Limits 1 ☑ Yes 2 ☐ No
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 1e marked other then "naturel", or items 23e or 28e-f show myn njury or other treumatic event. The Medicul Eventries must be rotified at once.	Funerai Dir	743 V. FuHon 11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 ⋈ No	.S. 13. \	10f. Zip Code 2 2 7 Was Decedent of Hi f Yes, specify Cubar	spanic Origin? (S n, Mexican, Puer	Specify Yes or No		ce - Americ	an Indian,
altimore, Maryland 21215-0036 mit. Pages 1 and 2 should be tiled within 72 hours alt partment of Health and Mental Hygiene. portant: If item 27 is marked other then "naturel", or yinjury or other treumatic event. The Mudical Enum 68.	Ď	3 ⊠ Widowed 4 □ Divorced 15. Decedent's Edu (Specify only highest grade	If Yes, Give Year or Dates:	16a. Deced	1 ☐ Yes 2 ☒ No dent's Usual Occupa kind of work done d	uring most of wa	orking	Specif	13100	-11
nd 212' e filed withir al Hygiene. I other then went. Ire M	Be Completed	Elementary/Secondary (0-12) Letty G 20de 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	C00	OO NOT use retired,		me (First, Middle,	Baker Maiden Suman	<u>2 V</u> ne)	
Marylai d 2 should b th and Ments 7 le marked treumatic e	To	Lee O. Hunt 19a. Informant's Name/Relationship (Ty	pe, Print)		g Address (Street a		ural Route Numb	-		1117
Baltimore, N permit. Pages 1 and Department of Health Important: If item 27 any injury or other to		20a. Method of Disposition 1 🖾 Burial 2 Cremation 3 🗆 F 4 Donation 5 Other (Specify)	emoval from State	lace of Dispo	sition (Name of natory or other place	9)	Date Date	20c. Location	· City or To	wn, State
Balt permit. Departi Importi any inj		21. Signature of Funeral Service License		22 VC	Name and Address	s of Facility	Funeral E	SVC		
Physician /Medical		23a. Part1. Enter the fishese, or complishock, or heart famile. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	ITRA	er the mode of dying		c or respiratory a	rrest,		Approximate Interval Between Onset and Death
Examiner	iner	Sequentially list conditions,	Sua to (or as a conseq	MON!	ARY E		,			
58760, cate be executed physician and sthe burial-transit	dicai Examiner	Cause (Disease or Injury that initiated events resulting in death) Last	DEEP Due to (or as a consequence of the ARTER 105)	uence of):	OTIC H		,	, LEG		
Division of Vital Records, P.O. Box 68760, To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)				ate of delive	ry Day Year
cords, P. w requires that the bean signed by should be detailed.	ed by Ph	Part II. Other significant conditions cor	ntributing to death but not rest			n in Part I.				e cause of death?
of Vital Reco Physician: The law re this certificate has be ral director, page 2 sho	Completed							osy rmed?/	Were autor prior to con death? 1 \(\sum \text{Yes}\)	osy findings available npletion of cause of 2 No
Vita	Be c	25. Was case referred to medical examiner?	lospital:		Othe		ath (Check only o			
ilon of inding Phy ath. r: After this ie funeral d	ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injury Work	at	Home 5 ☐ Resident Property 1	dence 6 (Oth		')
Division ited or Attenders after death all Director: led in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specif)	ome, farm, stre	eet, factory, office		28f. Location (S City or Tox	Street and Numb vn, State)	er or Rural	l Route Number,
Di To the Hospitel or within 24 hours afte To the Funeral Dis completely filled in	Medical	one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death tion and/or inv	estigation, in my op	inion, death occi	e, and due to the urred at the time,	cause(s) and ma date and place,	anner as sta and due to	ated. the cause(s)
Vait To Corr	2	29b. Signature and title of certifier	MD.		29c. License			29d. Date signer	•	
V		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type,	Print) 130 60 W 131	N SEC	ST. 13.	1203P	MO	. 21223
Sta Registr		SUDHIR. I 31. Date filed (Month, Day, Year) NOV 0 6 200	32. registrar's Signa	ture	asks					

Ε

Please Type or Print in Black Indelible Ink

rnest Hickman		State of Maryland / Department of Health and Mental 1-For State Registrar Certificate of Death		eg. No. 200	6 3512
Physiciar Medical Examin	1/	1. Decedent's Name (First, Middle, Last) ERNEST HICKMAN	2. Date of Dea Month October 2	ith = 000	3. Time of Death 0500 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Dea 1923 East Hoffman Street Baltimore	ath	4c. County of Dea	th
Funeral Director	- 2	2 F 35 Yrs.	Ain. //-//	-52 Fore	irthplace (State or ign SOUK) ountry) (ACO/WA
Maryland 28a-f show any d at once.	Ī	Usual Residence of Decedent 10a State 10b. County NA BAHIMORE			10d. Inside City Limits 1 No
th the Maryland 23a or 28a-f sho notified at once	Il Director	1923 E. HOAMAN St. 10f. Zip Code 2/2/3		og. Citizen of What Co	(<u></u>
er death wi	by Funeral	11. Marital Status 1 Never Married 2 Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No specify: 1 Yes 2 No specify:	rto Rican, etc.)	14 Race - Ame White, etc. Specify:	rican Indian, Black,
21 3 =	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) HANCY MAN	retired)	16b Kind of Business EMPI	New YEA
2121 ild be fil Mental F marked event,	8	17. Father's Name (First, Middle Last) 18. Mother's Name 19. Mailing Address (Street and Wilmberton) 19. Mailing Address (Street and Wilmberton)	me (First, Middle, Mid	Maiden Surname) Maiden Surname) Maiden Surname) Maiden Surname) Maiden Surname) Maiden Surname) Maiden Surname)	ey Zip Code)
MD and 2 sh alth an em 27 i		20a Method of Disposition. 20a Method of Disposition (Name of cemetery, 20a Method of Disposition)	NSt Z	206 Location - City o	r Town, State
Baltimore, permit Pages La Department of He Important: If ite injury or other to	-	1 Burial 2 Cremation 3 Removal from State Corporatory of other places 4 Donation 5 Other Specify 21 signature of Funeral Service Judysee 22 Name and Address of Facility	-1-06 Wthia P.C	SAMORE (DEGMA. PREMALINI-
Physician	+	23a. Hart I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.	c or respiratory arre	E BAIL est, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a Thermal injuries and smoke inhalation Due to (or as a consequence of):			Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause			
ecuted and transit		(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d			
60, ate be exe hysician a e burial -	ed <u>ic</u> ;	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy		Look Burney	
Box 6876 c death certificate the attending phy ed for use as the b	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic preg	gnancy	23d. Date of delive Month	ry Day Year
, P.O. B res that the d signed by the be detached	2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		obacco use contribute to	
Records The law requi	Completed		1 🗸 Yes	psy prior to rmed? death?	utopsy findings available completion of cause of es 2 No
Vital F	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nurrel Other		Residence 6 V Other	er. Scene
ion of V tending Phy eath. or: After th		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury 2Bb. Time of Injury 0407 hrs 1 Yes 2 No		how injury occurred red in house fire	
Division ospital or Attendin hours after death.	Certification	3 Suicide 6 Could not be determined (Specify) Townhouse / Rowhouse	2Bf. Location (S or Town, S 1923 East H	Street and Number or R State) Hoffman Street, Ba	ural Route Number, City
To the Hosp within 24 ho To the Func completely (edical	29a Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, all which one one one of the date and place of examination and/or investigation, in my opinion, death occurred and manner stated.			
	ž	29b Signature and title of certifier 29c. License number O.C.M.E.		October 27, 200	
		30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2	21201	•	
Sta Registra	te ar	31 Date filed (Month, Day, Year) N. 0 6 2006 32 Tegistrar's Signature			

		•	For State Registrar	State of M	laryland	•	irtment of H		Mental Hyg	iene	6 3	35127
			Decedent's Name (First, Middle.)	Last)		,			2. Date of Deat	h		3. Time of Death
	Physicia /Medic		Junior Earnest	Iden					August	03, 200	06	12:44 P ^M
	Examin		4a. Facility Name (If not institution,	give street and number)		4b. City, Town, or	Location of Dea	th	4c. County of		
			6107 Sensel Road	d			Hancock			Washin	ngton	1
	Funeral			6. Sex 7. A 1 ☑ M 2 ☐ F	ge (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs Hours Min		Year)	9. Birthplac	ce (State or Foreign
	Director		220-28-3991	X W ZUF	•	76 Yrs.			April O		WV	
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation				100	d. Inside City Limits
	Mary	ō	MD Washin	oton	Нат	ncock						11∑Yes 2 □ No
	28a	Director	10e. Street and Number	Stoll	Tidi	ICOCK	10f. Zip Code		1	0g. Citizen of Wh	at Countr	v?
	3a ou		6107 Sensel Ro	ad			21750			USA		
	ms 2	ere	11. Marital Status	12. Was Deceden	t Ever in U.S		Vas Decedent of Hi	spanic Origin? (Specify Yes or No-	14. Race -		
Maryland 21215-0036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Forces ad 1 □ Yes 2 ☑ If Yes, Give Year or Dates	No		Yes, specify Cubai	Specify:	rto Rican, etc.)	Black, Specify:	Black, White, etc. Specify: White	
2	72 ho	Completed	15. Decedent (Specify only highest	s Education			lent's Usual Occupa kind of work done d		orkina	16b. Kind of Busi	ness/Indu	stry
2	ithin	р	Elementary/Secondary (0-12)	College (1-4or	5+)	life. L	OO NOT use retired,)	, , , , , , , , , , , , , , , , , , ,			
7	ed wi ygien yer th	S	7			Labor	er			Cown of I		ck
<u>l</u>	be fill d oth	Be	17. Father's Name (First, Middle, L	ast)				18. Mother's Na	me (First, Middle, M	Maiden Sumame)		
₹	ould Men Marke	၉	Ernst Iden						<u>Stottler</u>			•
Jar	2 sho		19a. Informant's Name/Relationsh						ural Route Number			code)
ď	l and lealth sm 27 sher t		Cathy E. Smith/	Daughter	Joh Bl	2166	Old Natio	nal Pik	e Hancock	, MD 21	750	
ŏ	ges It of h If ite		20a. Method of Disposition 1 Burial 2 Cremation	3 □Removal from State	3		sition (Name of natory or other place	1		20c. Location - C	•	
Baltimore,	t. Partmer		'4 □Donation 5 □ Other (Sp		Alp				07/06 E			
Ва	permit. Pages 1 and Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service	Cansae .			. Name and Addres		141 West			
			23a. Part1. Enter the disease, or	complications that cause	d the death.				P.A. Har			Approximate nterval Between
ľ	Pnysician /Medical Examiner		shock, or heart failure. List & Immediate Cause (Final disease or condition resulting in death)	a. Due to (or a	muc	ence of):	hidu	Jue	ness	,~~~	رم . ار	nterval Between Onset and Death
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or a	s a consequ	ence of):						
	ecute Ind trans	Examiner	that initiated events resulting in death) Last	c								
8760,	cate be executed physician and the burial-transit	Ē	resulting in death) Last	Due to (or a	s a consequ	ence of):						
	physi the t	dicai		d							-	
P.O. Box 6	The law requires that the death certifinate has been signed by the attending to age 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant a	2 Fetal	death 3	Ectopic pregnancy Other (specify)			23d. Date Month	,	ay Year
	s that ned b	y Pr	Part II. Other significant condition	s contributing to death	but not resu	lting in the ur	derlying cause give	n in Part I.	23e. Did tob	acco use contrib	ute to the	cause of death?
g	w requires that been signed b should be det	ed b							1876	s 2 □ No 3	☐ Probab	oly 4 □Unknown
Records,	The law re tte has bee page 2 sho	Completed							24a. Was an autops perform	y prid ned? dea	ere autops or to comp ath? Yes 2	y findings available bletion of cause of
Vital	Physician: Th r this certificate ral director, pag	BeC	25. Was case referred to medical examiner?	-				26. Place of De	ath (Check only on			
	hysic his ce I dire	10	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpat	ient 2 🗆 E	ER/Outpatien	t 3□ DOA Othe	r: 4 🗌 Nursing	Home 5 eside	nce 6 Other	(Specify)	
0	ding P. h. After tl funera		27. Mann Death 1 Natural 5 Pending	28a. Date of Inj (Month, D	ury a <i>y</i> Year)	28b. Time of Injury	28c. Injury Work	at ?	28d. Describe ho	w injury occurred	J	
<u>si</u>	Attending ir death. sctor: After by the fune	cati	2 ☐ Accident investig	ation			M 1 🗆 Y	′es 2 □ No				
Division of	l or Attsno after death Dirsctor:	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 286. Place of it	njury - At hor atc. (Specify)	me, farm, stre)	eet, factory, office		28f. Location (St. City or Town	reet and Number I, State)	or Rural F	Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier 12 Certifying	Physician: To the bes	t of my know	vledge, death	occurred at the tim	e, date and plac	e, and due to the ca	use(s) and manr	er as stat	ed.
	he Ho in 24 i he Fu pletei	Medical	(Check only 2 Medical E	xaminer: On the basis and manner s	of examinati	on and/or inv	estigation, in my op	inion, death occ	urred at the time, da	ate and place, an	due to th	ne cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	11 1. 1	500	14	29c. License	number	25	9d. Date signed (Month, Da	ay, Year)
			30. Name and address of person v	no completed cause of	death (Item	23a) (Type,	Print)	007	, , ,	- ugas	50	0006
			Frederie	11 CASS	للا	mi	1111/	Me	dreal (enpas	Xe)	
	Sta		31. Date filed (Month, Day, Year)		trar's Signati	ure	The same of the sa		1 1			* A
DU	Registr	201	NOV 0 6	ZUUb	se d	1 130			· · ·	cours	Lu	n ma

State of Maryland / Department of Health and Mental Hygiene, 35128 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Vear **Physician** : 35 AM October RAYMOND R. JOHNSON 2 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner UNION MEMORIAL HOSPITAL BALTIMORE Date of Birth (Month, Day, Year) 04/14/1946 5. Social Security Number 7. Age (In vrs. last birthdav If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) **Funeral** Days Months 218-44-89 43 Usual Residence of Decedent MD Director 60 death with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10b. County 1 X Yes 2 □ No Director MD BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code in and Mental Hygiene. 7 is marked other than "natural", or items 23a or-traumatic event, the Medical Examiner must be r USA 1907 EDGEWOOD ST Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: BLACK 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12TH JANITORIAL DAY WORK 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BEATRICE ROBINSON ပ္ RAYMOND JOHNSON, SR. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a 1829 W. NORTH AVE., BALTIMORE, MD 21217 DOLORES ROBINSON other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c, Location - City or Town, State 5500 O'DONNETLL ST. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 Department of Important: If any injury or once, 4 □ Donation 5 □ Other (Specify) 10/27/2006 BALTIMORE, MD 21224 21. Signature of Furieral S 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 2007-09 EASTERN AVE., BALTIMORE, MD 21231 23a. Part1. Enter the dis-shock, or heart fail. Immediate Cause (Final disease or condition resulting in death) e, or complications that consed the List only one cause of ach line sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death endocarditis **Physician** Nee /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Physician/Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trans that initiated events resulting in death) Last neumonia Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. physician the as attending IF FEMALE nse If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 ☐ Yes 2 □ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 s autopsy performed

1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2√No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 Inpatient 2 ER/Outpatient Medical Certification: To 3 DOA this Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation Injury 2 □ No 1 ☐ Yes thin 24 hours after death.

the Funeral Director: A
impletely filled in by the fu 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2100 32 Registrar's Signatu 31. Date filed (Month, Day, Year State NOV 0 6 2006 Registrar

		1 - For State Registrar		epartment of Health and I Certificate of Death	Mental Hygien Reg. N	2006 25120
Physici		1. Decedent's Name (First, Middle, Last) PATRICIA M. JEI	UNINGS		2. Date of Death Month Da	3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, give s 907 PRESTWOOD		4b. City, Town, or Location of Death	h 40	County of Death 3AUTIMORE
Funeral Director		5. Social Security Number 6. Sex		day) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.		9. Birthplace (State or Foreign Country)
D		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location	100:14:1-10	10d. Inside City Limits
the Man 28a-feh Ictiffed	ector	MD N A	BALTIMO		100 0	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
h with 1	al Dir		ENUE	10f. Zip Code 21223	Tog. C	U8A
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other treumatic event, the Medical Examinar must be notified at any blues.	by Funeral Director		12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	pecify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: BLACK
21215-0036 d within 72 hours af giene. of than "naturel; or	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) (Decedent's Usual Occupation Give kind of work done during most of work life. DO NOT use retired)	rking	Kind of Business/Industry
d 21%		9 TH GRADE 17. Father's Name (First, Middle, Last)	N A CC	IRE PROVIDER	me (First, Middle, Maide	CHILD CARE
ylanc buid be fi Mental H arked ot atic ever	To Be	JAMES DAVENPORT		LOREMA	_	n Sumame)
re, Maryland 1 and 2 should be file Health and Mental Hy em 27 ie marked oth tther treumatic event		19a. Informant's Name/Relationship (Typ. KENSON DAVENPORT	, ,	Mailing Address (Street and Number or Ru		or Town, State, Zip Code) 2120
Baltimore, permit. Pages 1 an Department of Heal important: if items once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	cometen	Disposition (Name of crematory or other place)		Location - City or Town, State
Balti permit. Departir importa eny inju		21. Signature of Funeral Service License		22. Name and Address of Facility VAUGHN C. GREENE 5151 BAUD. NAT PIKE	FUNERAL S BAGO. M	SERVICE D 21229
Physician /Medical Examiner		23a. Part1. Enter de disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. Do not le cause on each line.		c or respiratory arrest,	Approximate Interval Between Onset and Death
cate be executed physician and inhe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of			
BOX 6 death certiff e ettending d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 1 ☐ Yes 1 ☐ Unknown	3c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
ords, P.O requires that the	by	Part II. Other significant conditions con	ntributing to death but not resulting in	the underlying cause given in Part I.		use contribute to the cause of death?
Has b	Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
of Vital F Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?			ath (Check only one)	
- × v 0	٦. To	1 Yes 2 No	lospital: 1 ☐ Inpatient 2 ☐ ER/Outp 28a. Date of Injury 28b. Ti		dome 5 Residence	6 ☐Other (Specify) ury occurred
Vision Attending r death. sctor: After	atlor	Natural 5 Pending investigation	(Month, Day Year) In	jury Work? M 1 ☐ Yes 2 ☐ No	0	
in Diffic	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury · At home, fare building, etc. (Specify)	m, street, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
Hospitei 24 hours a Funerei l	dical	29a. Certifier Check only 2 Medical Examin	sician. To the bast of my knowledge, ner: On the basis of examination and and manner stated.	death occured at the lime, date and place for investigation, in my opinion, death occu	e, and doe to the cause(urred at the time, date a	s) and manner as stated. nd place, and due to the cause(s)
To the To the complet	Me	29b. Signature and title of certifier		29c. License number DOS7936	29d. D	rate signed (Month, Day, Year)
3		30. Name and address of person who co		Type, Print)	o Britan	ure Mo 212261.
St	ate	31 Date filed (Month Day Year)	ouel Wo 90	Speak Merica	E BOWING	WC 1000 01000(.

06-08219 Please Type or Print in Black Indelible Ink Renar Semaj James State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day October 31, 2006 Year 0540 hrs Medical Examiner RENAR SEMAJ JAMES 4a. Facility Name (if not institution, give street and number) 4b City, Town, or Location of Death 4c County of Death Anne Arundel Route 295 and Nursery Road Linthicum 8. Date of Birth (MM/DD/YYYY) 9 Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs **Funeral** ST. CROIX Months Days Hours Director 580-13-3001 D3/11/1971 1 X M 2 F 34 Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits any 1 X Yes 2 No 28a-f show N/A BALTIMORE once, MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country notified at 5903 EASTCLIFF DRIVE 21209 U.S.A. Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black X Married Armed Forces? White etc. Never Married Yes Divorced If Yes, Give Year Yes 2 X No specify Widowed Specify BL ACK ğ 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 event, the Medical 12 ELECTRICIAN ELECTRICAL and Mental Hygiene. 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JAMES RHENEY 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5903 EASTCLIFF DRIVE - BALTIMORE, MD 21209 SARAH JAMES / WIFE Department of Health at Important: If item 27 injury or other traum: 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Burial 2 Cremation 3 Removal from State BALTIMORE HEBREW CONG 11/03/2006 REISTERSTOWN, MD Donation 5 Other Specify. 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode failure. List only one cause on each line. REISTERSTOWN ROAD - PIKESVILLE of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and /Medical Death a Multiple Injuries Immediate Cause (Final disease ***xaminer** or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and tran sician/Medical X AMENDED #7, perFH, G861, 11/6/06 TT ysician a UNPENDED Box 68760, IF FEMALE 23d Date of delivery the l If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown P 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Þ ے 1 Yes 2 No 3 Probably 4 Unknown pleted 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has death? performed? ✓ Yes 2 1 Com 1 🗸 Yes 26.Place of Death (Check only one To the Hospital or Attending Physician: 25. Was case referred to medical of Vital Be Other₄ Hospital: Inpatient ER/Outpatient 3 Nursing Home 5 Residence 6 V Other. Scene 1 Yes No 28a. Date of Injury (Month Day Year) Oct 31, 2006 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred After 27. Manner of Death Certification: Driver auto-fixed object collision 0000 hrs Natural 1 Yes 2 V No Pending in by the I 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide or Town, State) Route 295 and Nursery Road, Linthicum, MD To the Funeral (Specify) Major Road / Highway Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 1 29b Sigpature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E October 31, 2006 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar NOV 0 6 2006 DHMH 17 Rev 1/2001

			1	For State Registrar		State o	f Mary		partme ertifica			i Mental F	lygier	20	06	3513	
		ysiciar	n	1. Decedent's Name <i>(First, M</i> Kathryn		rdine	Koz1	owski				2. Date of Month Novem	_{Death} ber	^{Day} , 20	006°	3. Time of Death 3:50 p	
	7	Medica amine		4a. Facility Name (If not institu		treet and nur	nber)			Town, or	Location of De			4c. Count	y of Death		
	Fun Dire	eral ctor		5. Social Security Number 235-38-5699	6. Sex	м 217 г	7. Age (In	yrs. last birtho	y) If Und	r 1 Year	If Under 24 H Hours M		Birth Day, Yes		9. Birthp	e place (State or Forei ntry) ryland	ign
. M .	ith with the Maryland 23s or 28s-1 ehow	iffied at	-	Usual Residence of Decedent 10a. State 10b. Cou Md. Bal		e		c. City, Town o							1	10d. Inside City Limi	
A	with th	the or	DIE.	10e. Street and Number 2300 Dulane	y Val	ley Rd	. C-3	311		p Code 21093	3		10g.	Citizen of	What Cour	ntry?	
3:50	ter dea	Examinar m	<u>~</u>	11. Marital Status 1 ☐ Never Married 2反 1 3 ☐ Widowed 4 ☐ Divor	Married	2. Was Dece Armed Fo 1 Tes If Yes, Giv Year or D	rces?	in U.S.	3. Was Dec If Yes, sp		ispanic Origin? In, Mexican, Pu Specify:	(Specify Yes or erto Rican, etc.)	No-		ce - Americ ck, White,		
10	1215- within 72 ene. then "nat	the Mark	ompiete	15. Dece (Specify only his Elementary/Secondary (0-1				(G	cedent's Us ive kind of w e. DO NOT Tech	ork do n e d use retired	ation during most of a l)	vorking			ersity	_{dustry} y Hospita	7
	and be file of oth	2		17. Father's Name <i>(First, Mide</i> John Dorsey	ile, Last)						18. Mother's Mary	B. Sh	ile, Maid		718)		
	Maryland nd 2 should be file lith and Mental Hy 27 Is marked oth	other traumatic		19a. Informant's Name/Relati		-	nd					Rural Route Nur					
NOVEMBER	altimore, mit. Pages 1 as partment of Hea portent: If Item	y or othe		20a. Method of Disposition 1 Burial 2 Cremati 4 Donation 5 Othe		emoval from	State		rematory or	other plac	ery 11-	Date - 6-06			· City or To		_
	Baltimor permit. Pages Department of I	eny Injui	ľ	21. Signature of Junera Serv					22. Name a	nd Addres	s of Facility	eral Ho					
•	Physic /Med Exam	ical iner	amner	23a. Part1 Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	, or complication only on a b	Due to (or as a cor	nsequence of):	anter the mo	de of dyin	g, such as card	ac or respirator	r arrest,	2120		Approximate Interval Between Onset and Death	
	P.O. Box 687 thet the death certificate ad by the attending phys	for use as the bur	riiysiciaivimedicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 → No 9 □ Unknown	litions con	3c. If yes, out 1 Live b 4 Pregn 9 Unkno	come of printh 2 ant at time	Fetal death of death	3 □Ectopic s 5 □ Other (s • underlying	oecify)		23e. Di	- d tobacc	М	ate of delive	ony Day Year ne cause of death?	
RYN	Records, he law requires to be hes been signed.		ופופות	Pas Les C	\$ S C	3109						1 [24a. W			3 ☐ Prob	psy findings availab	-
7	tal Rec in: The lav	or, page 2		25. Was case referred to med	ical							au pe 1 ☐ Yes	topsy flormed	?	prior to cor death? 1 Yes	mpletion of cause of	Ĩ
KI,	of Vital Physician:	director To Re	2	examiner?				2 ER/Outpa			or: A Nursing	eath Check on Home 5 ☐ Re		6 □Oth	ner <i>(Specit</i>)	1)	
KOZLOWSKI	Afte Afte	ed in by the funera	Cation		iding estigation ald not be	28a. Date of (Mont			М		rat ⟨? Yes 2 □ No	28d. Describ	e how in	ijury occur	red		
XOZ	To the Hospital or Attend within 24 hours effer death To the Funerel Director:	led in by		4 ☐ Homicide det	ermined	buildir	ng, etc. (Sp					City or 1	own, Sta	ate)		l Route Number,	
2	the Hospital in 24 hours the Funeral	Medical	במוכם _	(Check only 2 Medi	hyin Pavs Famin	er: On the ba	isis of exam	knowledge d mination and/o	investigatio	n, in my op	oinion, death oc	ne, and due to the curred at the time	e, date a	(a) and mi and place,	annar as et and due to	the cause(s)	
	To With	E 00	Ξ	29b. Signature and title of per	ifier	60	12	de	29	c. License	number 5		29d. 0		d (Month, i		
	10 1			30. Name and address of pers			e of death		-	NEY	VALLEY	ROAD	TIM	ONIUI	M MD	21093	
	Re	State gistrar	•	31. Date filed (Month, Day, Ye NOV	0 6 2		egitrar's S	Signature	Board	es o				-			

3:50 P.M.

NOVEMBER 2 2006

	1	For State Registrar	tate of Maryland	/ Depa	rtment of He tificate of D	ealth and M leath	Ra	g. No.	
Physicia	กุ	1. Decedent's Name (First, Middle, Last) Anita Jean	Lowman				2. Date of Death Month Novembe	Day Year	3. Time of Death 3:30 P M
/Medica Examine		la. Facility Name (If not institution, give stre			4b. City, Town, or L			4c. County of Deat	
Funeral		Summit Park Health 5. Social Security Number 6. Sex	7. Age (In yrs. las	st birthday)		If Linder 24 Hrs	8. Date of Birth	Baltimore	hplace (State or Foreign
Director		214-44-6582 Usual Residence of Decedent	2 Ø F 59	Yrs.	Months Days	Hours Min.	Month, Day, April 26	,1947 Ma	ryland
yland		10a. State 10b. County		Town or Lo					10d. Inside City Limits 1 ✓ Yes 2 □ No
the Mar	ecto	Maryland N/A		Baltin	nore		10	Og. Citizen of What Co	
th with	ai Dir	124 Weber Street			212			U.S.A.	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Madical Examinar must be notified at	by Fur	11. Marital Status 1. Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in U.S. Armed Forces? 1		Was Decedent of His f Yes, specify Cuban 1 ☐ Yes 2 ☑ No	panic Origin? (Spe , Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	
Maryland 21215-0036 nd 2 should be filed within 72 hours att tith and Mental Hygiene. 27 is marked other than "natural", or rtraumatic event, the Mudical Expiri	Completed	15. Decedent's Educat (Specify only highest grade c	College (1-4or 5+)	16a. Deced (Give life.	dent's Usual Occupat kind of work done du DO NOT use retired)	iring most of work	ing	16b. Kind of Business, Home	Industry
il Hygie other i	0	9 17. Father's Name (First, Middle, Last)	0		Homemaker	18. Mother's Name	_	Maiden Sumame)	
Ylar tould be tould b	ToB	Leroy M. Low	vman	10b Mailir	Address (Street as	Jean		Ringle City or Town, State, A	Zip Code)
Maind 2 shall hand 27 is no	1		(Aunt)					Maryland 21	
Baltimore, Department of Hea Department of Hea Importent: if item any injury or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Ren	noval from State	netery, crer	sition (Name of natory or other place)		20c. Location - City or	
altim mit. Pa partmen portent: rinjury ise.	ì	4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee) HOI		SS Cem.	1		orookiyn ra Ome P.A. Saltimore,	ark,Maryland
Bal permi Depar impo eny ii		23a. Part1. Enter the disease, or complica	Janes						Maryland Approximate
Wedical Examiner whysicien and print the purial-transit	al Examiner	Sequentially list conditions, flam, leading Cause (Final disease or condition resulting in death) Sequentially list conditions, flam, leading to a mindfall cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	ence of):	ich				Interval Between Onset and Death
Geath certific death certific	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	. If yes, outcome of pregnan 1□Live birth 2 □ Fetal of 4□ Pregnant at time of dea 9□ Unknown	death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	livery Day Year
S, es the digner of the d	۾	Part II. Other significant conditions contr	buting to death but not resul	ting in the u	nderlying cause give	n in Part I.		pacco use contribute to es 2 X No 3 ☐ P	o the cause of death? robably 4 DUnknown
II Records, P.O. The law requires that the cate has been signed by the page 2 should be detach.	Completed						24a. Was a autops perform	sy prior to	utopsy findings available completion of cause of s 250 No
of Vital Physician: T this certificate ral director, pe	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	spital: 1 Inpatient 2 E	R/Outpatie	nt 3□ DOA Othe	26. Place of Deal		ence 6 □Other (Spe	ocify)
	on: T	27. Manner of Death 1 X Natural 5 ☐ Pending		28b. Time o	Work	at ? ′es 2 □ No	28d. Describe ho	ow injury occurred	
	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, st		63 2 110	28f. Location (Si City or Town	treet and Number or R n, State)	ural Route Number,
Hospite 14 hours Funeral tely filled	Medical Co		cian: To the best of my know r: On the basis of examinati and manner stated.						
To the within 2 To the comple	Me	29b. Signature and title of certifier	An.	MO	29c. License	number	2 /	29d. Date signed (Mon	th, Day, Year)
3		30. Name and address of person who com	pleted cause of death (Item Z 5 N 32 Registrar's Signate	23a) (Type	Print) Street	+ Re	resters	down	21136
Sta Registr		31. Date filed (Month, Day, Year) NOV 0 6 2006	32 Registrar's Signate	иге	arte				

	0.00		1 - For State Registrar	State of M	Maryland / [Departmer <i>Certificat</i>				Reg. 12	000	35133
1 3 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Physici /Medic		1. Decedent's Name (First, Middle, La:		L	2005			2. Date of D Month	eath Day	2, 200 year	3. Time of Death 2. SO PM
	Examir		4a. Facility Name (If not institution, give		ər)	4b. City	Town, or 57	Location of D		4c.	. County of Death	//
	Funeral Director		21, 22 1201	ex 7. □M 2 X F	Age (In yrs. last bir 90	thday) If Unde Months	r 1 Year Days	If Under 24 H	fin. July I	ay, Year)	9. Birthp	lace (State or Foreign http://MD
	Maryland	tor	Usual Residence of Decedent 10a. State 10b. County MD Carro	11	10c. City, Town	n or Location	Syke	sville			1	0d. Inside City Limits
	h with the 23a or 28	Funeral Director	10e. Street and Number 5956 Cecil Way			10f. Zij	Code 217	84		10g. Cit	izen of What Cour USA	itry?
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or Itams 23a or 28a-f show mingoriant: if Itam 27 is marked other than "natural", or Itams 23a or 28a-f show mingoriant; if Itam 27 is marked other than "natural Le Indilled at ance."	b	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decede Armed Force 1 Tyes 27 If Yes, Give Year or Date	s? [] No	13. Was Dece If Yes, spe 1 Yes			? (Specify Yes or Nuerto Rican, etc.)	0-	14. Race - Americ Black, White, Specify: Whi	
21215-0	id within 72 ho giene. er then "natu	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 12			Decedent's Usu (Give kind of wo life. DO NOT u Bookkee	ork done d se retired	luring most of	working		ind of Business/Ind	
Maryland	12 should be filed within 'h and Mental Hygiene. 7 is marked other than "	To Be (17. Father's Name (First, Middle, Last, Warren Lee Le					18. Mother's	Name (First, Middle a I. Sc	, Maiden hamb	,	
	and 2 sho salth and I n 27 is mu		19a. Informant's Name/Relationship (. Mailing Address 96 Malla			Arnold	MD 2		Code)
altimore,	permit. Pages 1 and: Department of Health Important: If Itam 27 any injury or other tr. 2005e.		20a. Method of Disposition K□ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif.		20b. Place of cemeter Wards	Disposition (Na y, crematory or Chapel (me of other place Cemet	ery 11	Date /6/2006		dallstow	
Balt	Departition of the point of the		21. Signature of Funeral Service Licer	Hull	_	HATCH Sykesy	ille	ERĀĽIIIVH , MD 2	OME & CHA 1784 (410	PEL)-79	PA (Box 5-1400	195)
	Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	a	n line.	engest	-		_	arrest,		Approximate Interval Between Onset and Death
8760,	eath certificate be executed attending physician and for use as the buriat-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequence							
O. Box 6	Q o Q	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death t at time of death	3 □Ectopic p 5 □ Other (s					23d. Date of delive Month	ery Day Year
rds, P.	50 00	ed by PI	Part II. Other significant conditions of	contributing to deat	h but not resulting in	n the underlying (cause give	on in Part I.			use contribute to the	ne cause of death?
Vital Records,	The law rete has be page 2 sh	Completed								s an opsy ormed? 2 No	prior to con death?	psy findings available mpletion of cause of
Vita	Physician: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othe		Death (Check only	one)		
of	After	ation: To	1 Yes 2 No 27. Mann r of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of I (Month,	njury 28b. 1		28c. Injury Work	4 Nursin	g Home 5 Res			y)
Division	or fite	Cert fication:	3 Suicide 4 Horniciae 6 Could not be sate mine of	288. Place of	Injury - At home, fa etc. (Specify)	rm, street, factor	y, office			(Street ar own, State	nd Number or Rura e)	l Route Number,
	Mospital 24 hours a Funeral E	edical	29a. Certifier 1 ☐ Certifying Ph (Check only one)	nysician: To the be miner: On the basis and manner	est of my knowledge s of examination an stated.	e, death occurred d/or investigation	at the time n, in my of	e, date and pl pinion, death o	ace, and due to the ccurred at the time	cause(s , date and) and manner as sid d place, and due to	ated. the cause(s)
	To the within 2 To the comple	Med	29b. Signature and title of certifier	M Mar.	1	29	c. License	number 54443			te signed (Month,	
/	7'		30. Name and address of person who				307		minste		MO 2	1157
	Sta Regist		31. Date filed (Month, Day, Year) NOV 0 6 200	6 32. Reg	istrar's Signature	barte			1			

06-08041 Sh

Please Type or Print in Black Indelible Ink

5-U8U4 I		Please Type of Print in Black		
herry Lloyd		State of Maryland / Department of Hea	Ith and Mental Hygiene	
,,	4	- For State Certificate of Deal		Reg No. 2006 35/31
		Registrar		
Physicia		Decedent's Name (First, Middle, Last)	2. Date of	
	11//		Month	er 25, 2006 Year 2315 hrs
ledical Examii	ier	Sherry Terrell Cloyd		
		4a. Facility Name (if not institution, give street and number) 4b. City,	Town, or Location of Death	4c. County of Death
		St. Agnes Hospital Balti	more	N/A
		Ot. / Ignes / lospital		The state of the s
Funeral	\neg	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Und		of Birth (MM/DD/YYYY) 9. Birthplace (State or
Director	- 1	Mont	hs Days Hours Min.	Foreign Country)
Director		219-04-10388 1 M 2 F 37 Yrs.	ns Days Hours Wiri. De	- 1,1968 Country) 19d
	1	Usual Residence of Decedent		
>	١-	10a State 10b. County 10c. City, Town or Location	<u> </u>	10d Inside City Limits
any	1	Tob. County		1 N N - 0 N -
- Š J	, Ι	Md N/A Baltimore		1 Yes 2 No
land	ᅙ	710	- 0-4-	10g. Citizen of What Country?
th the Maryland 23a or 28a-f show notified at once.	Director	10e Street and Number	p Code	Tog. Calizert of virial country :
or 2	.≝∣		7 8	USA
ith th		3000	?ia15	
s 2.		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent	lent of Hispanic Origin? (Specify Yes	
4 F 4	e	1 Never Married 2 Married Armed Forces? If Yes, spec	ify Cuban, Mexican, Puerto Rican, etc	.) White, etc.
r death w	.≣∣	1 Yes 2 No	N -	
i i ii ii ii ii ii ii ii ii ii ii ii ii		3 Widowed 4 Divorced If Yes, Give Year 1 Yes	2 No specify:	Specify. Black
iral nin	ᅀ	15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usua	Occupation (Give kind of work done	16b, Kind of Business/Industry
iour xar	교	during most of w	orking life. DO NOT use retired)	
12 1	ᇷ	Elementary/Secondary (0-12) College (1-4 or 5+)	TWI Z	11/
36 har	a	10th	istant Manage	/ McDonalds
S the s r s	ĔΓ		18 Mother's Name (First, Mic	Hallo Maiden Surname)
ed v	Completed	17. Father's Name (First, Middle, Last)	18 Mother's Name (First, Mic	ade, Mader Surfame)
우 를 무 등 합니	Be	Montell Cours	Barbara	114100
21215-0036 uld be filed within 72 hours after Mental Hygiene marked other than "natural", e event, the Medical Examiner	m l	7 10.00	ss (Street and Number or Rural Rout	e Number, City or Town, State, Zip Code)
	٩	19a Informant's Name/Relationship (Type, Print) Daughbor 19b. Mailing Address		
MD nd 2 sho alth and m 27 is aumati	·	Shervicka A. Manies 3606 Va	ahmont Ave Ba	Himore Md 21215
≥ 2 da la la la la la la la la la la la la la	- }	9.64 10.04 10.1	me of cemetery Date	20c. Location - City or Town, State
ages I and 2 shount of Health and Mit. If item 27 is no other traumatic		Zod. Motified of Diepoenter.		A
th = of		1 Burial 2 Cremation 3 Removal from State	D. Walasta	
Page Page nent aut:		4 Donation 5 Other Specify Mtombourn July 5 12	W: PK 1/0/31/0	O Arbubus Ma
in in in in in in in in in in in in in i	Ì	21. Signature of Juneral Service Licensee 22. Name ar	d Address of Facility Chairm	an - Harris FUNERU Home
Baltímore, permit Pages I a Department of He Important: If ite injury or other to			2	0 . 111 0
Ш &Д = .≡		Lever fares 52401	huisterstown no	Baltimore Md 21215
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode	e of dying, such as cardiac or respirato	ary arrest, shock, or heart Approximate Interval
/Medical	- 1	failure. List only one cause on each line.		Between Onset and Death
-		Immediate Cause (Final disease a Cardiac arrhythmia due to car	rdiomyopathy	Beaut
Examiner	- 1			
	- 1	Due to (or as a consequence of):		
		,		
and the same of th		Sequentially list conditions, b		
rayan spill	er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):		
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		
	aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated		
ed ssit	xaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of):		
cuted md transit	I Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated		
executed an and al - transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): d.	11 /07 /04 FIE	
), be executed sician and urral - transit	dical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): d. AMENDED #23a 27 perMF. C861.	11/27/06 TT	
60, sate be executed by social and the burial - transit	dical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		23d Date of delivery
8760, ifficate be executed gphysician and as the burial - transit	dical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): d. AMENDED #23a, 27, perME, C861. IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal deal		23d Date of delivery Month Day Year
68760, certificate be executed ndmg physician and se as the burial - transit	dical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	h 3 Ectopic pregnancy	To the second se
ox 68760, ant certificate be executed attending physician and or use as the burial - transit	dical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): d. AMENDED #23a 27 perMF. C861 AMENDED #23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death Pregnant at time of death 5 Other (S)	h 3 Ectopic pregnancy	To the second se
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit	dical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): d. AMENDED #23a 27 perMF. (2861) July 10 to (or as a consequence of): Due to (or as a consequence of):	h 3 Ectopic pregnancy pecify)	Month Day Year
5. Box 68760, the death certificate be executed by the attending physician and ached for use as the burial - transit	Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): d. AMENDED #23a 27 perMF. C861 AMENDED #23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death Pregnant at time of death 5 Other (S)	h 3 Ectopic pregnancy pecify)	To the second se
that the death certificate be executed ned by the attending physician and detached for use as the burial - transit	Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): d. AMENDED #23a 27 perMF. (2861) July 10 to (or as a consequence of): Due to (or as a consequence of):	h 3 Ectopic pregnancy necify) ng cause given in Part I. 23e	Month Day Year
res that the death certificate be executed signed by the attending physician and be detached for use as the burial - transit	d by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): d. AMENDED #23a 27 perMF. (2861) July 10 to (or as a consequence of): Due to (or as a consequence of):	h 3 Ectopic pregnancy pecify) ng cause given in Part I. 23e	Month Day Year Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 ✔ Unknown
ds, P.O. Box 68760, equires that the death certificate be executed een signed by the attending physician and build be detached for use as the burial - transit	d by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): d. AMENDED #23a 27 perMF. (2861) July 10 to (or as a consequence of): Due to (or as a consequence of):	h 3 Ectopic pregnancy pecify) ng cause given in Part I. 23e	Month Day Year Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 ✔ Unknown Was an 24b Were autopsy findings available
ords, P.O. Box 68760, w requires that the death certificate be executed is been signed by the attending physician and should be detached for use as the burial - transit	d by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): d. AMENDED #23a 27 perMF. (2861) July 10 to (or as a consequence of): Due to (or as a consequence of):	h 3 Ectopic pregnancy pecify) ng cause given in Part I. 23e	Month Day Year Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 V Unknown Was an autopsy findings available prior to completion of cause of
cords, P.O. Box 68760, e law requires that the death certificate be executed e has been signed by the attending physician and ge 2 should be detached for use as the burial - transit	d by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): d. AMENDED #23a 27 perMF. (2861) July 10 to (or as a consequence of): Due to (or as a consequence of):	h 3 Ectopic pregnancy pecify) ng cause given in Part I. 23e 1 24a	Month Day Year Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 ✔ Unknown Was an 24b Were autopsy findings available prior to completion of cause of death?
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	d by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): d. AMENDED #23a 27 perMF. (2861) July 10 to (or as a consequence of): Due to (or as a consequence of):	h 3 Ectopic pregnancy pecify) ng cause given in Part I. 23e 1 24a	Month Day Year Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 V Unknown Was an autopsy findings available prior to completion of cause of
II Records, P.O. Box 68760, The law requires that the death certificate be executed rufficate has been signed by the attending physician and for, page 2 should be detached for use as the burial - transit	d by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	h 3 Ectopic pregnancy pecify) ng cause given in Part I. 23e 1 24a 1 26 Place of Death (Check only one)	Month Day Year Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 ✔ Unknown Was an 24b Were autopsy findings available prior to completion of cause of death?
ital Records, P.O. Box 68760, ician: The law requires that the death certificate be executed s certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial - transit	d by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a cons	h 3 Ectopic pregnancy becify) Ing cause given in Part I. 23e 1 24a 1 26 Place of Death (Check only one)	Month Day Year Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 ✔ Unknown Was an autopsy performed? Yes 2 No 1 ✔ Yes 2 No
Vital Records, P.O. Box 68760, hysician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and al director, page 2 should be detached for use as the burial - transit	o Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a cons	h 3 Ectopic pregnancy pecify) Ing cause given in Part I. 23e 1 24a 1 26 Place of Death (Check only one) DOA Other Management of Nursing Home	Month Day Year Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 ✔ Unknown Was an autopsy performed? Yes 2 No 1 ✔ Yes 2 No Residence 6 Other
of Vital Records, P.O. Box 68760, g.Physician: The law requires that the death certificate be executed ther this certificate has been signed by the attending physician and neral director, page 2 should be detached for use as the burial - transit	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a cons	h 3 Ectopic pregnancy pecify) Ing cause given in Part I. 23e 1 24a 1 26 Place of Death (Check only one) DOA Other A Nursing Home	Month Day Year Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 ✔ Unknown Was an autopsy performed? Yes 2 No 1 ✔ Yes 2 No
n of Vital Records, P.O. Box 68760, ding Physician: The law requires that the death certificate be executed the Arter this certificate has been signed by the attending physician and signed by the burial of transit.	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a cons	h 3 Ectopic pregnancy pecify) Ing cause given in Part I. 23e 1 24a 1 26 Place of Death (Check only one) DOA Other Management of Nursing Home	Month Day Year Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 ✔ Unknown Was an autopsy performed? Yes 2 No 1 ✔ Yes 2 No Residence 6 Other
ion of Vital Records, P.O. Box 68760, tending Physician: The law requires that the death certificate be executed for: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial - transit	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a cons	h 3 Ectopic pregnancy pecify) Ing cause given in Part I. 23e 1 24a 1 26 Place of Death (Check only one) DOA Other Nursing Home 28c. Injury at Work? 1 Yes 2 No	Month Day Year Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 ✔ Unknown Was an 24b Were autopsy findings available prior to completion of cause of death? Yes 2 No 1 ✔ Yes 2 No 5 Residence 6 Other:
ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed red eath rector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial - transit	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a cons	h 3 Ectopic pregnancy pecify) Ing cause given in Part I. 23e 1 24a 1 26 Place of Death (Check only one) DOA Other's Nursing Home 28c. Injury at Work? 1 Yes 2 No Dry, office building, etc. 28f. Local	Month Day Year Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown Was an 24b Were autopsy findings available prior to completion of cause of death? Yes 2 No 1 Yes 2 No 5 Residence 6 Other: Scribe how injury occurred
Division of Vital Records, P.O. Box 68760, and a Attending Physician: The law requires that the death certificate be executed after death. After this certificate has been signed by the attending physician and birretor. After this certificate has been signed by the attending physician and ad in by the funeral director, page 2 should be detached for use as the burial - transit	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last List UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Ves 2 No 26. Due to (or as a consequence of): 27. Due to (or as a consequence of): 28c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (S): 9 Unknown 27. Manner of Death 1 XXNatural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28b. Time of Injury 28b. Place of Injury - At home, farm, street, factors.	h 3 Ectopic pregnancy pecify) Ing cause given in Part I. 23e 1 24a 1 26 Place of Death (Check only one) DOA Other's Nursing Home 28c. Injury at Work? 1 Yes 2 No Dry, office building, etc. 28f. Local	Month Day Year Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 ✔ Unknown Was an 24b Were autopsy findings available prior to completion of cause of death? Yes 2 No 1 ✔ Yes 2 No 5 Residence 6 Other:
Division of Vital Records, P.O. Box 68760, pital or Attending Physician: The law requires that the death cartificate death errains certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial - transit	ertification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a cons	h 3 Ectopic pregnancy becify) Ing cause given in Part I. 23e 1 24a 26 Place of Death (Check only one) DOA Other 28c. Injury at Work? 1 Yes 2 No Dry, office building, etc. 28f. Loca or T	Month Day Year Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown Was an autopsy performed? Yes 2 No 1 Ves 2 No The residence 6 Other: Scribe how injury occurred ation (Street and Number or Rural Route Number, City own, State)
Division of Vital Records, P.O. Box 68760, tospital or Artending Physician: The law requires that the death certificate be executed the hours after death interesting the certificate has been signed by the attending physician and supering the funeral director, page 2 should be detached for use as the burial - transit	Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last List UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 XNatural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined 4 Due to (or as a consequence of): Due to (or as a consequence	becify) In grause given in Part I. 23e 1 24a 1 26 Place of Death (Check only one) DOA Other Nursing Home 28c. Injury at Work? 1 Yes 2 No Dry, office building, etc. 28f. Loca or T	Month Day Year Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown Was an autopsy performed? Yes 2 No 1 Ves 2 No 5 Residence 6 Other: Scribe how injury occurred ation (Street and Number or Rural Route Number, City own, State) e cause(s) and manner as started
Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: The law requires that the death certificate 1 Euhours after death of the this certificate has been signed by the attending phys tely filled in by the funeral director, page 2 should be detached for use as the b	Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a cons	becify) In grause given in Part I. 23e 1 24a 1 26 Place of Death (Check only one) DOA Other Nursing Home 28c. Injury at Work? 1 Yes 2 No Dry, office building, etc. 28f. Loca or T	Month Day Year Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown Was an autopsy performed? Yes 2 No 1 Ves 2 No 5 Residence 6 Other: Scribe how injury occurred ation (Street and Number or Rural Route Number, City own, State) e cause(s) and manner as started
Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: The law requires that the death certificate 1 Euhours after death of the this certificate has been signed by the attending phys tely filled in by the funeral director, page 2 should be detached for use as the b	Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of a consequence of a consequence of a consequence of a cons	the 3 Ectopic pregnancy operity) Ing cause given in Part I. 23e 1 24a 1 26 Place of Death (Check only one) DOA Other Nursing Home 28c. Injury at Work? 1 Yes 2 No Dry, office building, etc. 28f. Locar T the time, date and place, and due to the my opinion, death occurred at the time	Month Day Year Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown Was an autopsy findings available prior to completion of cause of death? Yes 2 No 1 Yes 2 No 5 Residence 6 Other Scribe how injury occurred ation (Street and Number or Rural Route Number, City own, State) e cause(s) and manner as started of date and place, and due to the cause(s)
Box 68760 to death certificate I the attending physed for use as the bigging the best of the breakful the attending the breakful the br	ertification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of a consequence of a consequence of a consequence of a cons	becify) In grause given in Part I. 23e 1 24a 1 26 Place of Death (Check only one) DOA Other Nursing Home 28c. Injury at Work? 1 Yes 2 No Dry, office building, etc. 28f. Loca or T	Month Day Year Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown Was an autopsy performed? Yes 2 No 1 Ves 2 No 5 Residence 6 Other: Scribe how injury occurred ation (Street and Number or Rural Route Number, City own, State) e cause(s) and manner as started
Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: The law requires that the death certificate 1 Euhours after death of the this certificate has been signed by the attending phys tely filled in by the funeral director, page 2 should be detached for use as the b	Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of an expected to the part of the part of the part of the pa	be in a lettopic pregnancy opecify) Ing cause given in Part I. 23e 1 24a 1 26 Place of Death (Check only one) DOA Other Nursing Home 28c. Injury at Work? 1 Yes 2 No 28f. Locator T 28c. Injury at Work? 1 Yes 2 No 28f. Locator T 28c. Locator	Month Day Year Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 ✓ Unknown Was an autopsy performed? Yes 2 No 1 ✓ Yes 2 No 5 Residence 6 Other: Scribe how injury occurred ation (Street and Number or Rural Route Number, City own, State) e cause(s) and manner as started of date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)
Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: The law requires that the death certificate 1 Euhours after death of the this certificate has been signed by the attending phys tely filled in by the funeral director, page 2 should be detached for use as the b	Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of an expected to the part of the part of the part of the pa	the 3 Ectopic pregnancy operity) Ing cause given in Part I. 23e 1 24a 1 26 Place of Death (Check only one) DOA Other Nursing Home 28c. Injury at Work? 1 Yes 2 No Dry, office building, etc. 28f. Locar T the time, date and place, and due to the my opinion, death occurred at the time	Month Day Year Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown Was an autopsy findings available prior to completion of cause of death? Yes 2 No 1 Yes 2 No 5 Residence 6 Other Scribe how injury occurred ation (Street and Number or Rural Route Number, City own, State) e cause(s) and manner as started of date and place, and due to the cause(s)
Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: The law requires that the death certificate 1 Euhours after death of the this certificate has been signed by the attending phys tely filled in by the funeral director, page 2 should be detached for use as the b	Certification: To Be Completed by Physician/Medical	Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last AMENDED	be in a lettopic pregnancy opecify) Ing cause given in Part I. 23e 1 24a 1 26 Place of Death (Check only one) DOA Other Nursing Home 28c. Injury at Work? 1 Yes 2 No 28f. Locator T 28c. Injury at Work? 1 Yes 2 No 28f. Locator T 28c. Locator	Month Day Year Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 ✓ Unknown Was an autopsy performed? Yes 2 No 1 ✓ Yes 2 No 5 Residence 6 Other: Scribe how injury occurred ation (Street and Number or Rural Route Number, City own, State) e cause(s) and manner as started of date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)
Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: The law requires that the death certificate 1 Euhours after death of the this certificate has been signed by the attending phys tely filled in by the funeral director, page 2 should be detached for use as the b	Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Live birth 2 Fetal death 2 Pregnant at time of death 5 Other (Signature and for investigation, in and manner stated) 25. Was case referred to medical examiner? 1 Yes 2 No 9 Unknown Part II. Other significant conditions Due to (or as a consequence of): AMENDED #23a 27 perMF. (2861. 25. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions Contributing to death but not resulting in the underlying to death but not resulting in the underlying labeled (Specify) 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Nanner of Death 28a. Date of Injury At home, farm, street, factor (Specify) 28a. Place of Injury - At home, farm, street, factor (Specify) 28b. Signature and title of certifier 1 Certifying Physician: To the best of my knowledge, death occurred at and manner stated 29b. Signature and title of certifier 1 Certifying Physician: To the basis of examination and/or investigation, in and manner stated	h 3 Ectopic pregnancy pecify) Ing cause given in Part I. 23e 1 24a 1 26 Place of Death (Check only one) DOA Other'a Nursing Home 28c. Injury at Work? 1 Yes 2 No Dry, office building, etc. 28f. Loca or T the time, date and place, and due to the my opinion, death occurred at the time 29c. License number O.C.M.E.	Month Day Year Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown Was an autopsy performed? death? Yes 2 No 1 Yes 2 No 5 Residence 6 Other: scribe how injury occurred ation (Street and Number or Rural Route Number, City own, State) e cause(s) and manner as started e, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) October 26, 2006
Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: The law requires that the death certificate 1 Exhancus after death of the this certificate has been signed by the attending physely filled in by the funeral director, page 2 should be detached for use as the by	Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (S) 9 Unknown Part II. Other significant conditions Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (S) 9 Unknown Part II. Other significant conditions Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (S) 9 Unknown Part II. Other significant conditions Contributing to death but not resulting in the underlying (Month, Day, Year) Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (S) 9 Unknown Part II. Other significant conditions Contributing to death but not resulting in the underlying (Month, Day, Year) Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (S) 9 Unknown 25. Was case referred to medical examiner? Live birth 2 Fetal death 5 Other (S) 9 Unknown 26a. Date of Injury (Month, Day, Year) Live birth 2 Fetal death 5 Other (S) 9 Unknown 27. Manner of Death 1 Inpatient 2 ER/Outpatient 3 Very (Month, Day, Year) Live birth 2 Fetal death 5 Other (S) 9 Unknown 28a. Date of Injury - At home, farm, street, factor (S) (Specify) 28a. Place of Injury - At home, farm, street, factor (S) (Specify) 28b. Signature and title of certifier Medical Examiner: On the basis of examination and/or investigation, in and manner stated.	be in a lettopic pregnancy opecify) Ing cause given in Part I. 23e 1 24a 1 26 Place of Death (Check only one) DOA Other Nursing Home 28c. Injury at Work? 1 Yes 2 No 28f. Locator T 28c. Injury at Work? 1 Yes 2 No 28f. Locator T 28c. Locator	Month Day Year Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown Was an autopsy performed? death? Yes 2 No 1 Yes 2 No 5 Residence 6 Other: scribe how injury occurred ation (Street and Number or Rural Route Number, City own, State) e cause(s) and manner as started e, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) October 26, 2006
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death To the Put norral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the by	Medical Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Last College of Injury that initiated events resulting in death) Last Last College of Injury that initiated events resulting in death) Last Last College of Injury and Investigation and address of person who completed cause of death (Item 23a) Due to (or as a consequence of): Due to (or a	h 3 Ectopic pregnancy pecify) Ing cause given in Part I. 23e 1 24a 1 26 Place of Death (Check only one) DOA Other'a Nursing Home 28c. Injury at Work? 1 Yes 2 No Dry, office building, etc. 28f. Loca or T the time, date and place, and due to the my opinion, death occurred at the time 29c. License number O.C.M.E.	Month Day Year Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown Was an autopsy performed? death? Yes 2 No 1 Yes 2 No 5 Residence 6 Other: scribe how injury occurred ation (Street and Number or Rural Route Number, City own, State) e cause(s) and manner as started e, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) October 26, 2006
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death To the Tuneral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the by	Medical Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The particulary to the to the to the to the to the to the to the to the to the to the to	h 3 Ectopic pregnancy pecify) Ing cause given in Part I. 23e 1 24a 1 26 Place of Death (Check only one) DOA Other'a Nursing Home 28c. Injury at Work? 1 Yes 2 No Dry, office building, etc. 28f. Loca or T the time, date and place, and due to the my opinion, death occurred at the time 29c. License number O.C.M.E.	Month Day Year Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown Was an autopsy performed? death? Yes 2 No 1 Yes 2 No 5 Residence 6 Other: scribe how injury occurred ation (Street and Number or Rural Route Number, City own, State) e cause(s) and manner as started e, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) October 26, 2006
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death To the Put norral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the by	Medical Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The particulary to the to the to the to the to the to the to the to the to the to the to	h 3 Ectopic pregnancy pecify) Ing cause given in Part I. 23e 1 24a 1 26 Place of Death (Check only one) DOA Other'a Nursing Home 28c. Injury at Work? 1 Yes 2 No Dry, office building, etc. 28f. Loca or T the time, date and place, and due to the my opinion, death occurred at the time 29c. License number O.C.M.E.	Month Day Year Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown Was an autopsy performed? death? Yes 2 No 1 Yes 2 No 5 Residence 6 Other: scribe how injury occurred ation (Street and Number or Rural Route Number, City own, State) e cause(s) and manner as started e, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) October 26, 2006
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death To the Tuneral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the by	Medical Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The particulary to the to the to the to the to the to the to the to the to the to the to	h 3 Ectopic pregnancy pecify) Ing cause given in Part I. 23e 1 24a 1 26 Place of Death (Check only one) DOA Other'a Nursing Home 28c. Injury at Work? 1 Yes 2 No Dry, office building, etc. 28f. Loca or T the time, date and place, and due to the my opinion, death occurred at the time 29c. License number O.C.M.E.	Month Day Year Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown Was an autopsy performed? death? Yes 2 No 1 Yes 2 No 5 Residence 6 Other: scribe how injury occurred ation (Street and Number or Rural Route Number, City own, State) e cause(s) and manner as started e, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) October 26, 2006

06-08270 Leonard McMillan

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2	0	0	6	3	5	-	3	5

		1- For State Registrar		Certific	cate of i	Death			Re	g. No	100	3313
Physicia		1. Decedent's Name (First, Middle	e,Last)					Mo	ite of Deat	Day Year		Time of Death
edical Exami	ner	Leonard		Reed		McMill		No	vember	1, 2006		1610 hrs
		4a. Facility Name (if not institution Greater Baltimore Med		-)	4k	. City, Town, or Lo Towson	cation of	Death		4c. County of Baltimore		h.,
							10.13	our los	S. J. EDIA			,
Funeral Director				ge (In yrs last bii	rthday)	If Under 1 Year Months Days	If Under Hours	Min.		,	9 Birthp	olace (State or Foreign i try)
Director		218-68-7464	1 X M 2 F	52	Yrs.			07	7 20	54		WV
8		Usual Residence of Decedent		Iso or Tr								
w any		10a. State 10b. County		10c. City, Towr							ı	0d Inside City Limits
Maryland 28a-f show d at once.	ō	MD NA		Balt:	imore							1 X Yes 2 No
Mary 28a- d at	Director	10e. Street and Number				10f. Zip Code			10	g Citizen of Wha		13
ith the Maryland 23a or 28a-f sho notified at once.		1008 Evesham	Ave			2.	L212			U.S	. A .	
215-0036 be filed within 72 hours after death with the Maryland nital Hygiene riked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	uneral	11. Marital Status 1 Never Married 2 X Ma	12. Was Deceden			Decedent of Hispa s, specify Cuban, N				14. Race - White.		n Indian, Black,
or its	Fun		1 Yes 2	2 XXNo					, , ,			
after ral",	ğ	3 Widowed 4 Div	orced If Yes, Give Year or Dates:			res 2 X No				Specify:		Black
5-0036 led within 72 hours afte Hygiene other than "natural", the Medical Examiner		15. Decedent's Education (Spec				s Usual Occupation st of working life. D			one	16b. Kind of Bus	iness/Ind	ustry
336 thin 72 than "	Completed	Elementary/Secondary (0-12) 12th grade	College (1-4 or na	5+)	Truc	k Drive	٦r			Constr	uct	ion Co.
with with her the	E	17 Father's Name (First, Middle,	1		11.00			Name (First	Middle M	faiden Surname)	ucc	1011 001
filed at Hy	BeC	Hollis Harri	•					dine		. ,		
21215-00 und be filed wit Mental Hygier marked other c event, the M	0	19a. Informant's Name/Relations		19	9b. Mailing	Address (Street a					State Z	ip Code)
MD 21215-0036 d 2 should be filed within 7 th and Mental Hygiene a 27 is marked other than unnatic event, the <u>Medica</u>	-	Robyn McMill	an-Wife	- 3		Eveshar						21212
_ = = = =		20a. Method of Disposition		20b. Place	of Disposit	on (Name of ceme		Date		20c. Location - I		
Baltimore, MD 2121 Degerni Pages I and Should be fill Department of Health and Memal important: If frem 27 is marked njury or other traumatic event,	Ì	1 Burial 2 X Cremation		itate	atory or othe		-	33/2	. /0.			3
Itimer Trumer Trumer System		4 Donation 5 Other Sp 21. Signature of Funeral Service		Metro		ematory			3/06	Baltim	ore	, Ma
Baltimore, permit Pages I a Department of He Important: If ite injury or other tr		Wille	2-1-)	Mar	me and Address o	Wes	t	0-1-	i	الم 1/4	21215
Physician	-	23a. Part I. Enter the disease, or	complications that cause	d the death. Do r		00 Wabas mode of dying, su						Approximate Interval
/Medical		failure. List only one cause		matia sami	ld							8etween Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Atheroscle		HOVASC	ular disea	se					
		Sequentially list conditions,	b.									
1	ē	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a cons	sequence of):								
	Examiner	(Disease or injury that initiated	c. Due to (or as a cons	sequence of):							-	
ecuted and transit		events resulting in death) Last	d.									
2 - 1	n/Medical	X UNPENDED		20 27	Æ -0	(1 11/00/	oc nm					
8760, trificate be ex ng physician as the burial	Jed	IF FEMALE:	#2 23c. If yes, outco			61, 11/30/0	D 11			23d Date of d	delivery	-
3876 rtificat ing ph	Jug	23b Was decedent pregnant in the past 12 months?			2 Feta	il death 3	Ectopic p	pregnancy		Month	Day	y Year
Box 6 e death cer the attendi	Sici			at time of death	5 Oth	er (Specify)				Ì		
Records, P.O. Box 6 The law requires that the death cer cate has been signed by the attending page 2 should be detached for use	Physicia		9 Ouknown	alle les a sea sea al la		4.4 (: . D		20- 0-1-	<u> </u>		
P.O s that t gned by	by	Part II. Other significant condit	ions contributing to dea	ith but not resulti	ng in the un	derlying cause giv	en in Pari	11.				e cause of death?
S, F puires n sign								- +				
cords law requi	Completed	<u> </u>							24a. Was a autop:	sy pr	ior to con	osy findings available in npletion of cause of
Reco	mo							1	✓ Yes 2		eath?	2 No
	Φ	25. Was case referred to medica				26.Place o	f Death (0	Check only o	ne)			
Vite	o B	examiner? 1 ✓ Yes 2 No	Hospital: 1 🗸 Inpat	ient 2 ER/0	Dutpatient	3 DOA	ther ₄	Nursing Hon	ne 5	Residence 6	Other:	
Division of Vital Records, rat or Attending Physician: The law requirate detect the transfer of the transfer at Director. After this certificate has been sited in by the funeral director, page 2 should be	<u>-</u>	27. Manner of Death	28a. Date of In (Month, Day	jury 28b	Time of In	ury 28c, Injury	at Work?	28d	Describe h	now injury occurre	d	
ion tendi	tio	1 X Natural 5 Pend 2 Accident Inves				1 Ye	s 2 1	No				
VISI or At free d in by	Lici			Injury - At home,	farm, street	, factory, office bui	lding, etc.				r or Rural	Route Number, City
Division of Vital Hospital or Attending Physician: 24 hours after death divector: After this certificity filled in by the funeral director,	Certification:		rmined (Specify)						or Town, S	tate)		
Divisior Hospital or Attend 24 hours after death Funeral Directors etely filled in by the		(one on only	hysician: To the best of r									
To the Ho within 24 } To the Fu completely	Medical	one) 2 Medical Exa	miner: On the basis of ex and manner stated		investigation	on, in my opinion, o	death occu	urred at the t	ime, date	and place, and du	e to the o	ause(s)
F×Fŏ	ž	29b. Signature and title of certifie				29c. License	number			29d Date signe	d (Month	, Day, Year)
		SHILL	VX DV			O.C.M	.E.			November 2	2, 2006	
4		30. Name and address of person	who completed cause of	death (Item 23a))							
		Susan Hogan MD.	Assistant Medical E	Examiner 1	111 Penr	Street, Baltin	nore, M	ID 21201				
	ate	110110	32. Re 6ti	rar's Signature	. 1.	and s						
Regist	-	H 1/11// /1	6 2006	WHE I LE	· 4							,

			State of Marylan		artment of H			iene 9. N 2 0 0 6	35136
			Registrar 1. Decedent's Name (First, Middle, Last)		tilleate of L	Jean	2. Date of Death		3. Time of Death
П	Physicia	เก		7	Vioronhor	C.	Month Novembox	Day Year r 2, 2006	
Q 17	/Medic Examin		Norman 4a. Facility Name (If not institution, give street and number)		Nierenber 4b. City. Town. or	Location of Death	Movembe	4c. County of De	
•	Examin	CI	Suburban Hospital		Bethesd			Montgor	nerv
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9 B	irthplace (State or Foreign Country)
	Director		333-14-6703 ^{1∑M 2□F} 87	Yrs.	Months Days	Hours Will.	May 8,	1919 1	Llinois
	p >		Usual Residence of Decedent 10a, State 10b, County 10c, City	y, Town or Lo	cation				10d, Inside City Limits
	laryla shov	'n							. 1 XYes 2 No
	the N	Director	D.C. Was	shingto	On 10f. Zip Code		10	og, Citizen of What (Country?
	a or								
	eath	era	5420 Connecticut Ave. N.W. 11. Marital Status 12. Was Decedent Ever in U.	.S. 13. \	20015 Was Decedent of Hi If Yes, specify Cuba		ecify Yes or No-	U.S.A.	nerican Indian,
စ္တ	ges 1 and 2 should be filed within 72 hours after death with the Maryland t of Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	y Funeral	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No 1942	2	lf Yes, specify Cuba 1 □ Yes 2521 No	an', Mexican', Puèrto Specify:	Rićan, etc.)	Black, Wh	nite, etc.
Maryland 21215-0036	hours ural"	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1946		dent's Usual Occupa	ation		16b. Kind of Busines	White
7	"nat	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	kind of work done of DO NOT use retired	during most of work	ing	TOD. KING OF BUSINES	s/moustry
7	withi ene. than the M	Ĕ	Elementary/Secondary (0-12) College (1-4or 5+)	Eco	onomist	,	1	Federal Go	overnment
2	filled Hygi sther ent, t		17. Father's Name (First, Middle, Last)	130		18. Mother's Name			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
<u>la</u> n	lid be lental ked d	To Be	Isadore Nierenberg			Sadie Do	orfman		
ary	shou and M s mar umat	_	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street a	and Number or Run	al Route Number,	City or Town, State	, Zip Code)
2	무두 5 후		Andrew P. Nierenberg (Son)	17114	Gault St	t., Lake			
ore	of He fitem		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State	Place of Dispo cemetery, crei	sition (Name of matory or other plac		Date 2	20c. Location - City of	or Town, State
Ĕ	Pages ment of h ant; If ite ury or of				Mem. Par		5/06 1	Los Angele	es, CA
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other		21. Sign ture of Fi neral Service Licensee	22	2. Name and Addres	nai Mortu	ary	Annalas	CA 00069
			23a. Part1. Enter the disease, or complications that caused the death	h. Do not ent				Angeles,	Approximate
	Dhusisian	s 17	shock, or heart failure. List only one cause on each line.	diop	1	·	11		Interval Between Onset and Drath
	Physician /Medical		disease or condition resulting in death) Due to (or as a conseq			J'ar	9/		minus)
	Examiner		(m	ona	n all	y des	ease		years
'n.	蒙	Je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that instructions are not sequentially as a consequence of the conditions of the con	uonerof):	1	//			
	cate be executed physician and the burial-transit	Examiner	triat initiated events			<i>y</i>			
Ő,	e exe ian a urial-1	Ē	resulting in death) Last Due to (or as a conseq	juence of):					
8760,	ate b hysic the b	dical	d						
Ø	ing page as a	/Mec	IF FEMALE: 230 If yes, cuttoome of progre	2004					
Вох	attenc for us	Physician/Me	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf pregnant 1 □ Live birth 2 □ Feta	al death 3	□Ectopic pregnancy □ Other (specify)	1		23d. Date of d Month	lelivery Day Year
P.O.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	leaui 3L					
	that the the detail		Part II. Other significant conditions contributing to death but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use contribute	to the cause of death?
Sp	The law requires that the death certific the has been signed by the attending page 2 should be detached for use as	d by					1 ☐ Ye	es 2∎No 3□	Probably 4 □Unknown
Ö	s beer shou	Completed					24a. Was ar	n 24b. Were	autopsy findings available
Re	The lay te has age 2	шо					autops perform 1∐ Yes 2	ned? death	o completion of cause of ? es 2 □ No
ta	an: 'rtifica tor, p	Be C	25. Was case referred to medical			26. Place of Deat		<u>.</u>	55 20115
<u>`</u>	nysici nis ce direc	To B	examiner? 1 ☐ Yes 2 M No Hospital: 1 Inpatient 2 ☐] ER/Outpatier	nt 3 DOA Oth	er: 4 🗆 Nursing Ho	me 5 Reside	ence 6 Other (Sp	pecify)
0 0	ng Ph fter th neral		27. Manner of Death 28a. Date of Injury 1 X Natural 5 □ Pending (Month, Day Year)	28b. Time o Injury	f 28c. Injur Worl	y at k?	28d. Describe ho	w injury occurred	
Sio	endil eath. or; A	atic	2 ☐ Accident investigation		M 1	Yes 2 □ No			
Division or Vital Records,	To the Hospital or Attending Physician: The Within 24 hours after death. To the Funeral Director; After this certificate ha completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of injury - At h building, etc. (Specifi	ome, farm, sti <i>fy)</i>	reet, factory, office		28f. Location (St. City or Town		Rural Route Number,
	pital ours a eral I		29a. Certifier 1 X Certifying Physician: To the best of my kno	owledge deat	h occurred at the tir	me, date and place	and due to the ca	ause(s) and manner	as stated
	e Hos 24 h e Fur	edical	(Check only 2 Medical Examiner: On the basis of examination one)						
	To the twithin 24	Me	29b. Signature and title of certifier		29c. Licens	_	_	9d. Date signed Mo	nth Day, Year)
					9-	- 6088	+	1/21	26
/	27		30. Name and address of person was completed cause of death (Iter Jack Flyer, N.D. 8600 01d	n 23a) (Type,	Print)			814	
4	<i>O</i> Sta	te.				, _ , _ , _ ,	, 20		
	Registi		31. Date filed (Month, Day Year) 6 2005 32. Registrar's Signa	e Sis	Speciel 1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 2:15 PM Ruth Virginia Price November 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Glen Meadows Baltimore Glen Arm If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2XXF 214-38-2992 Director September 8.1920 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Maryland | Baltimore 1 ☐ Yes 2 X No Director Glen Arm 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 11630 Geln Arm Rd. 21057 United States Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) teacher, vice principal education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elmer Wesley Price Frances Marian Johnson ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12 Over Ridge Ct. Nancy Deeley/sister Baltimore, MD 21210 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenmount crematory Nov. 3,2006 Baltimore, Maryland 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, 21. Signature of Funeral Service Licensee 6500 York Rd. Baltimore, 23a. Port1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, bock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ONGESTIVE CAZDIAC FAILURE **Physician** DAY /Medical **Examiner** ARDIOMYUPA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit Due to (ar as a consequence of) Division or Vital Records. P.O. Box 68760. IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by THRUTU 1 ☐ Yes 20⊒ No. 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No after death death. the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number Signature and title of certifier 29d. Date signed (Month, Day, Year) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

			ricase	ype of Print in Bia				-	•	e.
			For	State of Maryland				, ,	000	6 05100
			1 - State Registrar		Certific	ate of	Death	R	ieg. No2 U U	5 35 38
	"走" 语	-14	1. Decedent's Name (First, Middle, Last)					2. Date of Dea	th	3. Time of Death
ilg.	Physici		JAMES	HENRY	POTTER	CD		Month		ear 12-20-M
	/Medic		4a. Facility Name (If not institution, give s				r Location of Death	NOV.	04 , 2006 4c. County of E	
-	Examin	er								
	*		4530 TAPSCOTT I			IKES der 1 Year	VILLE If Under 24 Hrs.	La Division		ORE CO.
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last	Yrs. Mont		Hours Min.	8. Date of Birth (Month, Day	, Year) 9.	Birthplace (State or Foreign Country)
	Director		228-20-4220	80	115.			2-3-19	926 NI	EW YORK
	pug *		Usual Residence of Decedent 10a. State 10b. County	10c City T	Town or Location					10d. Inside City Limits
	aryk e ho	7								1 X Yes 2 □ No
	8a-f	cto	MD BALTIMO	RE CO. PI	KESVIL.	LE				1 A 163 2 1160
	be filed within 72 hours after death with the Maryland ital Hygiene. ed other than "natural, or Itame 23a or 28a-f show avant, the Madical Exactine results in utilized at	Director	10e. Street and Number		10f.	Zip Code		1	0g. Citizen of Wha	t Country?
	th w		4530 TAPSCOTT	ROAD		2120	8		U.S.A.	
	dea	Funeral	11. Marital Status	2. Was Decedent Ever in U.S. Armed Forces?	13. Was De	cedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-		American Indian,
9	or its	E	1 Never Married 2X Married	1 DAYAS 2 No				rican, etc.)		White, etc. AMERICAN
ဗ	urs a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give 1944 Year or Dates: 194		s 2 ½ No	Specify:		Specify: F	INDIAN
21215-0036	within 72 hours after ene. than "natural", or fte	Completed	15. Decedent's Educ	cation 1	16a. Decedent's L	Isual Occup	ation		16b. Kind of Busin	
Ë	n"n	ple	(Specify only highest grade	College (1-4or 5+)	(Give kind of life. DO NO	work done Tuse retired	during most of work d)	ing	MARYLAN	ND
7	iene	E	12th	College (1*401 5+)	SECURI	ry gu	JARD			COMMISSION
0	filed Hygie other ant,		17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, i		
an	ntal od o	Be	RALPH	POTTER	•		MARGA			JNGER
2	should ind Men ind Men ind marke	٩				/2:				
Maryland	C1 00 == 48		19a. Informant's Name/Relationship (Type				and Number or Run			
	and lealth m 27 her tr		SHIRLEY WARD PO				TT RD.,	-		
Baltimore,	00		20a. Method of Disposition 1 ☐ Burial 2 ②Cremation 3 ☐ Re		e of Disposition (etery, crematory	Name of or other plac	ce)	Date	20c. Location - City	y or Town, State
Ĕ	permit. Pages Department of Important: If It any Injury or o		4 ☐ Donation 5 ☐ Other (Specify)	RIVE	RDALE (CREM.	11-6	-2006 H	RIVERDAI	LE, MD
<u>=</u>	permit. Departr Imports any Inju		21. Signature of Function Service Line	θ Λ .	22. Name	and Addre	ss of Facility TA			
œ.	Depa Impo any Ir		1/20	L VAN	1722	морт	אנ יים דס אם עי	UI GILL	TONERAL	SH. DC 20001
	e kil		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death. I						Approximate
	18 to 1		shock, or heart failure. List only on Immediate Cause (Final	e cabse on each line.				, ,		Interval Between Onset and Death
À	Physician		disease or condition resulting in death)	(M)	Char	2				
*	/Medical Examiner		Tooling in sound	Due to (or as a consequen	ice of):			2-	16.1	
M.	LAGITITICI		Sequentially list conditions, b	U	MINANY	Ta	set I	NTEG	Ten.	
	ב ס	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequen	ice of):					
	cute	am	that initiated events							
o	e be executed /sician and e burial-transit		resulting in death) Last	Due to (or as a consequen-	ice of);					
760	ysician yelorial	ca	d							
89	leath certificate t attending physic I for use as the b	ed								
Вох	ndin use	~	IF FEMALE: 23b. Was decedent pregnant	Bc. If yes, outcome of pregnancy					23d. Date of	deliven
ă	atte	cla	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal de: 4 ☐ Pregnant at lime of death		pregnancy	•		Month	Day Year
o.	the d	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	3 0 0 0 0 0 0	(Specify)				
٥.	The law requires that the death certifica ste has been signed by the attending ph page 2 should be detached for use as th	급	Part II. Other significant conditions con	tributing to death but not recultir	a in the undertain	5 63U60 00V	on in Part I	23a Did to	agge use contribut	te to the cause of death?
Records,	rest igne be d	ρ	51 1 15 to 14	C		ig causa giv	en in Faut.			
5	w require been si should t	Completed	Transportation,	Mart Duce	20/17			1 □ Ye	es 2 Mino 3	Probably 4 Unknown
ပ္ထ	as be	be						24a. Was a		autopsy findings available
	fhe tav te has age 2:	E						autops	ned? deat	
Vital	iffice or, p	C	25. Was case referred to medical				00 81 1 8	70.00	A	Yes 2 No
5	Attending Physicism: r death. setor: After this certifior by the funeral director, i	∞	examiner?	ospital:	10	DOA Oth	26. Place of Deatl			
ō	Phy this ral d	<u>۲.</u>	1 ☐ Yes 2 🔯 No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	1 inpatient 2 ER/	Outpatient 3. b. Time of	DOA	4 🗆 Nursing Ho		ence 6 Other (S	Specify)
2	ling After une	<u>6</u>	1 StNatural 5 ☐ Pending	(Month, Day Year)	Injury	28c. Injun Wor		zou. Describe no	w injury occurred	
<u>S</u>	teath tor: the	cat	2 Accident investigation 3 Suicide 6 Could not be		М		Yes 2□No			
Division of	after of Direction by	Certification;	4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, street, fac	tory, office		28f. Location (St. City or Town	reet and Number o. n, State)	r Rural Route Number,
	Ital Irs a ral D	ပ္ပ		1						
	To the Hospital or Attending Physicism: The I within 24 hours after death. To the Funeral Director: After this certificete his completely filled in by the funeral director, page	cal	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examin	ician: To the best of my knowled er: On the basis of examination	dge, death occurr	ed at the tin	ne, date and place,	and due to the ca	ause(s) and manne	r as stated.
	in 24 ha F plete	Medical	one)	and manner stated.			panion, death occurr	ou at the tille, Q	are and place, and	ane to the cause(s)
	To To E	Σ	29b. Signature and title of certifier	2/11	1//	29c. License	e number	25	9d. Date signed (M	onth, Day, Year)
) '			CD Vol	10 word	VII	,	03577	0	11-06	-86
1	U		30. Name and address of person who cor	npleted cause of death (Itam 23	(Type, Print)	-			1	0 6
IU			1. 1	RED.M.D.E.	Rolling	Crossi	sal sto	1021	Jan-11.	1-06 16, md 21228
74	Sta	e	31. Date filed (Month, Day, Year)	32. Resistrar's Signature	4	40	- 17d	101	11015011	el ina altas
	Registr		NOV 0 6 21		M. Ann					

			For State Registrar	State of	of Maryla	•	artment rtificate			ental Hyg	giene Reg. N2 0 0	6 3	35139
E.	Obverie		1. Decedent's Name (First, Midd)	e, Last)	-					2. Date of Dea Month	ath		3. Time of Death
	Physici /Medi		MARGARE	TY	PR	ESSE	R			NOV	1 200		5.00 P M
	Examir		4a. Facility Name <i>(If not institution</i> B rightwood	n, give street and nu	ımber)			wn, or Loc therv	ation of Death		4c. County o	^{f Death} ltimo	re
***	Funeral Director		5. Social Security Number 215-10-7575	6. Sex 1 ☐ M 2 💢 F	7. Age (In yrs 87	i. last birthday) Yrs.	If Under 1 Months		Under 24 Hrs. lours Min.	8. Date of Birth (Month, Day Aug. 2	1, 1919	9. Birthplac Country Mary	e (State or Foreign Tand
	and w		Usual Residence of Decedent 10a, State 10b, County		10c. C	ity, Town or Lo	cation					10d	. Inside City Limits
	d • ho	ō	,	imore		Parkton						100	1 ☐ Yes 2 🙀 No
	7.28a	rec	10e. Street and Number				10f. Zip C	ode _			10g. Citizen of W	nat Country	
3	23a o	ai Di	319 Stablers	Church Ro	ad		10f. Zip C 2	1120			US	Α	
36	permit. Pages 1 end 2 should be liled within 72 hours after death with the Maryland Deportment of Health and Mential Hygiene. Deportment of Health and Mential Hygiene. Book controller if them 27 is marked other then "natural", or items 23a or 28a-f show many injury or other treumatic event, the Medical Examinar mile the notified at Ance.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marri 3 ☑ Widowed 4 ☐ Divorced	Armed F ied 1 ☐ Yes If Yes G	2 ⊠ No ive		Was Deceder f Yes, specify 1 ☐ Yes 2	Cuban, M	nic Origin? (Sp lexican, Puerto pecify:	ecify Yes or No- Rican, etc.)	14. Race	- American , White, etc	
ğ	atura cal E	ted	15. Deceden	t's Education		16a. Deced	dent's Usual (Occupation	1		16b. Kind of Bus		
215	6	Completed	(Specify only higher Elementary/Secondary (0-12)	st grade completed, College (1-4or 5+)				g most of work				,
2	ygien ygien it.	Con	12			Admin	istrat		Assista		U.S.O.		
Maryland 21215-0036	Mental H Mental H Brked oth	To Be	17. Father's Name (First, Middle, John Weiss	Last)				18.		Doyle	Maiden Sumame)	
, Mar	end 2 sno salth and n 27 is ma er treuma		19a. Informant's Name/Relations Mr. Jim Matthews								r, City or Town, S On, Md.		
Baltimore,	rages 1 ent of He nt: If iten ry or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State	Place of Dispo cemetery, crem rrison	natory or othe	ar place)		-06	20c. Location - C		
Balt	Departm Importar any injui		21. Signature of Funeral Service		2		Name and	Addrose of	Egolih		e, Inc. ld. 21204		, , , , ,
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the dea	ath. Do not ent	er the mode	York of dying, su	Rd. To	OWSON, M or respiratory ari	ld. 21204 rest,	A _I	pproximate terval Between
	hysician		Immediate Cause (Final disease or condition	a EN	D 5	TAG	E T	EM	EN71.	A		\rightarrow \right	nset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a conse	quence of):							
4		70	Sequentially list conditions, if any, leading to immediate	U	for as a conse	E 7	0 74	1210	6			T.	uys_
7	ned insit	dical Examiner	cause. Enter Underlying Cause (Disease or injury		EPSI							de	74.0
,	incare be executed physicien and s the burial-transit	Еха	that initiated events resulting in death) Last	U	(or as a conse							CC	ugs
68760, ((())	ysicie	cal		L d	72							de	20
	⇒ O 0	6 0	IF FEMALE:										0
P.O. Box 6	es that the death celluing pigned by the attending pigned be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 Live	tcome of pregr birth 2 Fet nant at time of lown	al death 3 🗆	Ectopic preg Other (spec				23d. Date Mont	,	y Year
of Vital Records, P.O	ned b deta	by Pt	Part II. Other significant condition	ons contributing to a	leath but not re	sulting in the ur	nderlying cau	se given in	Part I.	23e. Did to	bacco use contrib	oute to the o	cause of death?
rds	pis or old blu	d ba								1 □ Y	es 2□No 3	Probabl	y 4 Hithknown
000	s been si	Completed								24a. Was a		ere autopsy	findings available
H H	is certificate has director, page 2	E								autops perfor	med? de	orto compl ath?]Yes 2[etion of cause of
E :	ctor, 1	Bec	25. Was case referred to medica examiner?	200				26.	Place of Deatl	(Check only or			2110
> \frac{1}{2}	this ce al dire	2	1 Yes 2 No	Hospital: 1 🗆	Inpatient 2	ER/Outpatien	t 3 DOA	Other:	Nursing Ho	me 5 Resid	ence 6 Other	(Specify)	
ם ס	After t funera	iio	27. Manner of Death 1 ■ Natural 5 ■ Pendin	g 28a. Date (Mor	of Injury oth, Day Year)	28b. Time of Injury		linjury at Work?		28d. Describe h	ow injury occurred	1	
Division of Vital Records,	ter deatlinector:	Certification:	2 Accident investigned a Suicide 6 Could determined	not be 28e. Place	e of Injury - At I	nome, farm, stra ify)	eet, factory, o	1 Yes		28f. Location (S City or Tow	treet and Number n, State)	or Rural R	oute Number,
o la contra	within 24 hours at To the Funerel D completely filled in	edical C	29a. Certifier 1 Certifyir (Check only 2 Medical one)	ig Physician: To the Examiner: On the b and mar	e best of my knoasis of examination	owledge, death ation and/or inv	occurred at restigation, in	the time, d	ate and place, n, death occurr	and due to the c ed at the time, d	ause(s) and mani late and place, an	ner as state d due to the	d. e cause(s)
, d	Mithin To the	Me	29b. Signature and title of certifie				29c. L	icense nur	mber	12	9d. Date signed	Month, Day	v. Year)
	0		> Spun	Je MD			20	05	3150	r	107 5,	1 d Z	006 -e110 21045
1	5	1	30. Name and address of person	who completed cau	se of death (Ite	т 23а) (Туре,	Print)		1.1	0 0		Sui	e 110
		-	5 hakun 31. Date filed (Month, Day, Kear)	maka	Sup	+-	465	050	antic	230 R	ead	COI	unbic
4334	Sta Registr	_	31. Date filed (Month, Day, Xear)	0 6 2006	register s Sign	lature &	A					MD	21045

			1 - State of Ma	aryland / Depa <i>Cei</i>	artment of H			iene 19. No 2006	35140
ı	Physici		1. Decedent's Name (First, Middle, Last) GENALDING	= RA	-MSA	4	2. Date of Death Month	Day, 2 Year	3. Time of Death A
-	/Medic Examin		4a. Facility Name (If not institution, give street and number)		/	Location of Death		4c. County of Dea	th 4.30
-	Funeral		Bon Secours Hospital 5. Social Security Number 6. Sex 7. Ag	e (In yrs. last birthday)	Balti If Under 1 Year Months Days	MOTE If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	N/A 9. Bir	thplace (State or Foreign
	Director		Usual Residence of Decedent	92 Yrs.			11 23		est Indies
	h the Maryland r 28a-f ehow	or	10a. State 10b. County MD NA	10c. City, Town or Lo					10d. Inside City Limits 10d. Yes 2 □ No
	or 28a-	Director	10e, Street and Number	Darcin	10f. Zip Code		10	0g. Citizen of What C	ountry?
	iter death with riteme 23a or	ai D	3415 Elgin Ave		21	.216		U.S.A	•
	er des	Funerai	11. Marital Status 12. Was Decedent Armed Forces?		Was Decedent of Hi If Yes, specify Cubai	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
215-0036	g 0 1	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√1 If Yes, Give Year or Dates:	10	1□Yes 21XNo	Specify:		Specify:	Black
ק	n 72 hours "natural" edical Ex	ietec	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired,	luring most of work	ing	16b. Kind of Business	/industry
212		Completed	12th grade College (1-4or 5	5+)	Foster P			State of	Maryland
and	t be file ntal Hyg of othe:	Be	17. Father's Name (First, Middle, Last) William Hamblin			18. Mother's Name		Maiden Sumame)	
Mary	should ind Men marke umatic	²	19a. Informant's Name/Relationship (Type, Print)	19b. Maili				City or Town, State,	Zip Code)
	s 1 and 2 should I Health and Mer Item 27 is marks other traumatic		Erline Brown-Daughter		5 Elgin			-	1216
altimore,	00-2		20a. Method of Disposition X□ Burial 2 □ Cremation 3 □ Removal from State	20b. Place of Dispo cemetery, crei	osition (Name of matory or other place	9)		20c. Location - City or	Town, State
<u>=</u>	nit. Pag artment ortant:: injury c injury c		4 □ Donation 5 □ Other (Specify) 2). Signa ur of Funeral Service, Licenaee	Evergi	reen 2. Name and Addres	11/8	/06 I	Brooklyn	NY
n	Depa Impo eny i		Signatura de la sovie de la so	(ina Ma	arch F/H	West	Baltin	nore, Md	21215
M.	Physician		refulting in death)	the death. Do not ent ne. 25/5					Approximate Interval Between Onset and Death
	/Medical Examiner		Due to (or as	a consequence of):	(LEI)	DIA	BETESE	MECLIN	5
	ed sit	iner	The state of the s	a consequence of):	6 TEIN		-		
,	be executed sician and burial-transit	Examin	C. C.	a consequence of):		,			
9/8	ate the	dicai	d	YPER,	TENS,	101			
O. Box 6	death e atter	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	livery Day Year
rds, P	law requires that the deas been signed by the a	þ	Part II. Other significant conditions contributing to death b	ut not resulting in the u	nderlying cause give	en in Part I.	23e. Did tob	pacco use contribute to	o the cause of death? robably 4 □Unknown
Vital Hecords,	o _ c @	Completed	- NECROSIS	OF G	77 \$	ete	24a. Was ar autops perform	y prior to death?	utopsy findings available completion of cause of
<u> </u>	iician: Th certificate rector, pag	Be C	25. Was case referred to medical			26. Place of Deatl		F	s 2 □ No
<u>></u>	Physician: this certific ral director,	၉	examiner? 1 Yes 2 Inpatie			4 LI Nursing Ho		nce 6 Other (Spe	ecify)
	Attending I ir death. ector: After by the funer	ation	27. Manner of Death Natural 5 Pending Accident investigation 28a. Date of Inju (Month, Da)	ry 28b. Time o y Year) Injury	Work	rat ⟨? Yes 2 □ No	28d. Describe no	w injury occurred	
DIVISION	b Hospital or Atten 24 hours after deat Funeral Director: etely filled in by the	Certification;	a Could not be	ury - At home, farm, str c. (Specify)	reet, factory, office		28f. Location (Str City or Town	reet and Number or R , State)	ural Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Attercompletely filled in by the funer	edical C	29a. Certifier (Check only one) Certifying Physician: To the best 2 Medical Examiner: On the basis or and manner sta	f examination and/or in	h occurred at the tim vestigation, in my op	ne, date and place, pinion, death occurr	and due to the ca red at the time, da	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
1	To the within 2 To the complet	Me	29b. Signature and title of certifier	ZETA K	29c. License	number	29	9d. Date signed (Mon	th, Day, Year)
,	27		30. Name and address of person who completed cause of d		Print)	1170	,	11/1/0	1-5-00-00
)		AMBACHEW WORE	TH MI	2431	MARY	(CAN) 1	THE IST	12/2/1
à	Sta Registr		31. Date filed (Month, Day, Year) 32. *** NOV 0 6 2006	ar's Signature	mark!				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death ROCHKIND Month OCTOBEIL Physician LILLIAN 10:45A 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner NORTHWEST JATI920H RANDALLSTOWN BALTIMORE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 RF 224-42-5408 101 RUSSIA Director 4/12/05 Usual Residence of Decedent 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10h County 10d. Inside City Limits MD BALTIMORE BALTIMORE 1 □Yes 🖈 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1003 SMOKE TREE ROAD 21208 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE Specify: 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be NATHAN **SPECTOR** SHIFRA MALKA ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, STANLEY ROCHKIND / SON 1003 SMOKE TREE ROAD - BALTIMORE, MD 21208 20b. Place of Disposition (Name of Date 20a Method of Disposition 20c. Location - City or Town, State BETH TORAH CEMETERY 1 Burial 2 Cremation 3 X Remoyal from State 11/01/2006 RICHMOND, VA. 5 ☐ Other (Special 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that case shock, or heart failure. List only one cause on pach sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final TVLACT URINAR INFECTION Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Duri to (or as a consequence of) day leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23h. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by RENAL FAILURE 1 ☐ Yes 2 ☑No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? perform 2 No 2**2**No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2**/25** No 1 hpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day Year) 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Procertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State

31. Date filed (Month, Day, Year) NOV 0 6 2006 Registrar

29b. Signature and title of certifier

NORTHWEST

5401 OLD COURT ROAD HOSPITAL 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

MITCEA

D5435

TODOR

29d. Date signed (Month, Day, Year)

MD

2006

21133

OCTOBER

PANDALISTOUN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Nov 2006 4:20am 4 Ronald G. Sapp 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Gilchrist Center Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth OCT . 25 , 1941 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Days Hours 1**√**M 2□F Maryland 214-38-6281 65 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Baltimore Essex 1 ☐ Yes X ☐ No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21221 USA 127 Hampshire Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. □Yes 2 XNo Yes, Give 1 Never Married 2 Married Specify: White 1 ☐ Yes 2X No Specify. 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MArtin's Mill Wright 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gertrude Dobbs Herman A. Sapp 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

127 HAmpshire Road Baltimore MD 21221

Suite 209, Touson MA 21204

permit. Pages 1 and Department of Healt Important: if Item 27 any injury or other tra

Physician

/Medical

Examiner

10a. State

Director

Completed by Funeral

Be

MD

Diane

Sapp

Black,

NOV 0 6 2006

Jason

31. Date filed (Montb,

65-65

/wife

Funeral

Director

than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at

s 1 and 2 should be fill thealth and Mental Hatem 27 is marked oth other traumatic even

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

physician and s the burial-trans Division or Vital Records, P.O. Box 68760, ed by the page 2 s

or Attending

the Hospital within 2.

n 24 hours after death.

Ie Funeral Director: Af

	20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	Name	Place of Disposition (A cemetery, crematory of Dlly Hill	lame of or other place) Cemetery	Date 11/9/0	1	cation - City or Ltimor	
	21. Signature of June al Service Licens	Cornelly		and Address of Facility				Balto.MD ex 21221
	23a. Part. Enter the discase of plants on or heart failure. His on or immediate Cause (Final disease or condition	Λ	th. Do not enter the m	ode of dying, such as card	liac or respiratory	arrest,		Approximate Interval Between Onset and Death Mo 4 Th S
niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):					Years
dical Exan	that initiated events resulting in death) Last	Due to (or as a consect.	quence of):					
hysician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregn 1□Live birth 2□Fet 4□Pregnant at time of 0 9□Unknown	al death 3 □Ectopio	c pregnancy (specify)		- 2	23d. Date of de Month	elivery Day Year
D F	Part II. Other significant conditions co	ntributing to death but not res	sulting in the underlyin	g cause given in Part I.			se contribute t □ No 3 □ F	o the cause of death? Probably 4
Completed					24a. W — au pe 1 Ye:	topsy rformed?	24b. Were a prior to death?	
Re	25. Was case referred to medical examiner?			26. Place of I	Death (Check oni	y one)	,	1 11124
0	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3□	DOA Other: 4 Nursin	g Home 5□Re	esidence 6	S Dether (Spe	ecity) HOSPICE
	27. Manner of Death 1 ♣ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describ	e how injur	y occurred	,
Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, street, fac	tory, office		n (Street and Town, State		Rural Route Number,
Medical (sician: To the best of my kn iner: On the basis of examin and manner stated.						
Š	29b. Signature and title of certifier	,		29c. License number				oth, Day, Year)
	Joron Blue	I ing		00061199		No	V, 4, 2	006
	30. Name and address of person who co	ompleted cause of death (Ite	m 23a) (Type, Print)					

State Registrar

SK

North Charles

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] 1 - For State Registrat Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month -20 PM 5TENZE1 KARL . F. NOU 2006 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMORE Cockeys vi lle
If Under 1 Year | If Under 24 Hrs. MARYLAND MASONIC NUTSING HOME Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 12M 2□ F Days Hours Min 215-16-7804 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County BALTIMORE 1 ZYes 2 □ No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3227 21213 U.S.A. RAMONA AUR 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Phone CORP 12th Mechanic DIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) STENZE trederick FOA YEAGER. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William 8819 BAKER AUE, BAlto. MO 21234 STENZEL 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State 11/7/06 BAlto. MD BALTIMORE CEIN. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
PAUL STELLA FUNERAL Home, PA
7527 housest RO. BALto. MS 21234 21. Signature of Funeral Service Licensee aul M. Stelle Approximate Interval Between Onset and Death 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) End Stage Carelw myopathe Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Winknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 → 100 autopsy performed? 1 Yes 20 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: 1 ☐ Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

Physician /Medical Examiner Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit use as i death. nours after deat within 24 hours a To the Funeral L

Physician

/Medical

Examiner

Funeral

Director

or items 23a or 28a-f show

Completed by Funeral Director

Examiner

Completed by Physician/Medical

Be

Certification: To

29a. Certifier

Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mantal Hyglene.
ant: If them 27 Is marked other than "naturel", or items 23s or 28s-f show ant: If them 27 is marked other than "naturel", or diver traumatic event, ith Madical Examples must be inclined at

permit. Page Department of Important: If any injury or once.

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year) NOV 0 6 2006

Robert Li Beito, Mo

29b. Signature and title of certifier

32. Rigistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3508 Bark ST. Balto, MS 21224

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D21464

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 35144

	1- For State Certificate C	f Death	Reg. No. 2000 3314
Physician/ Medical Examine	1. Decedent's Name (First, Middle,Last)	2. Date of De Month October 3	Day Year
)	Facility Name (if not institution, give street and number) Bon Secours Hospital	4b. City, Town, or Location of Death Baltimore	4c. County of Death N/A
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 47 Yr	Months Days Hours Min. Fab (irth(MM/DD/YYYYY) 9 Birthplace (State or Foreign)3, 1959 Rhode Island
faryland 28a-f show amy Lat once.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local 10d. Maryland N/A Baltimor		10d Inside City Limits 1 Yes 2 No
5-0036 led within 72 hours after death with the N tygiene. other than "natural", or items 23a or i the Medical Examiner must be notified Completed by Funeral Dir		10f. Zip Code 21223	10g. Citizen of What Country? U.S.A.
	3 Widowed 4 Divorced If yes, Give Year 1	as Decedent of Hispanic Origin? (Specify Yes or N Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes 2 No specify: nt's Usual Occupation (Give kind of work done	White, etc Specify: White
	Elementary/Secondary (0-12) College (1-4 or 5+) 12 Se	elf-Employed	16b Kind of Business/Industry Contractor
	Kalph F. Komano		Coyle
- p∄ ∈ #	Ralph S. Stagner (Brother) 2/00	g Address (Street and Number or Rural Route Nu County Road, 92, Cedar sition (Name of cemetery, Date	
. 드 은 은 등 등	1 Burial 2 Cremation 3 Removal from State Bayview (rematory 11-02-06	Baltimore, Maryland
Balti permit. Departu Import injury c	28a. Part I. Enter the disease, or complications that caused the death. Do not enter	Name and Address of Faculity Funeral O East Fort Avenue, Bal	rest, shock, or heart Approximate Interval
/Medical Examiner	failure List only one cause on each line. Narcotic intoxication complicated by Hypertensive Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Between Onset and Death Due to (or as a consequence of):		
red 	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		
ficate be executed g physician and the burial - transit	X UNPENDED #23a,27,28a-f,perME,g861,11/15/06 TT		
Division of Vital Records, P.O. Box 68760, for the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transiedical Certification: To Be Completed by Physician/Medical Executed.	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fergnant at time of death 5 C		23d. Date of delivery Month Day Year
i, P.O. B ires that the d signed by the 1 be detached i			tobacco use contribute to the cause of death?
Division of Vital Records, P.O tal or stending Physician: The law requires that it is after death. "al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacher frification: To Be Completed by F			
tal Rectinant: The certificate ector, page	25. Was case referred to medical examiner? Hospital: 4 Inpution: 2 FP/Outpution:		
Physical direction	1 Yes 2 No Inpatient 2 ER/Outpatier		Residence 6 Other:
in of ding Phase is Affer to the funeral ion: T	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of (Month, Day, Year) 28b	1 Yes 2 No	how injury occurred
isior Attencer death rector: by the	2 Accident Investigation 28e. Place of Injury - At home, farm, stre	1 A UIRTO	WN (Street and Number or Rural Route Number, City
Division ospital or Attending hours after death. neral Director: Aft filled in by the func Certification:	3 Suicide 6 X Could not be determined (Specify) found at residen	or Town	State) 314 Firmow Street
Description of the part of the			
F #F S B	29b. Signature and title of Certifier	29c. License number O.C.M.E.	29d Date signed (Month, Day, Year) November 1, 2006
	30. Name and a dress of person who completed cause of death (Item 23a) Mary G. Aipple MD. Deputy Chief Medical Examiner 11	1 Penn Street, Baltimore, MD 21201	
State 31. Date filed (Month, Day, Year) 32. Ref. strår's Signature			
DHMH 17 Rev 1/2001 ORIGINAL			

			1 - For State Registrar	State of	Maryland		artment rtificate			and M	_	giene Reg. No 2 (006	35145
	Physici	an	1. Decedent's Name (First, Middle, La	Sina)	oton						2. Date of De Month 10	ath Day 3 I	Year 06	3. Time of Death
	/Medic	al	Aldora M. 4a. Facility Name (If not institution, giv				4h Cih. I	Tourn or	Location of	of Dooth	10		nty of Death	8:30p. M
	Examin	er	3645 Hilmar Ro		<i>,</i>				lsor		1	40. 0001	N/A	
	Funeral		5. Social Security Number 6. S	ex 7	Age (In yrs. las	**	If Under Months		If Under Hours			th Y, Year) 1 24	9. Birth	place (State or Foreign ntry)
	Director		212-20-2857 1 Usual Residence of Decedent	□ M 2 5 F	82	Yrs.	teroritino.	Duys			01 04	24		MD
	ow a		10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City Limits
	e-fah	ctor	MD NA	Ą		Wind	dsor	MIl	.1					1X Yes 2 □ No
	or 28	Director	10e. Street and Number				10f. Zip					10g. Citizen o		ntry?
	s 23s	erai	3645 Hilmar Ro	oad 12. Was Deced	ant Ever in II S	12.1	Mac Dasad		244	ain? (Cna	of Vocasile		S . A .	oon lading
(0	r itam	Funerai	1 Never Married 2 Married	Armed Ford 1 Tyes 2 If Yes, Give	es?	1				i, Puerto	cify Yes or No Rican, etc.)	В	lack, White,	
93	172 hours after deeth with the Maryland "natural", or Itama 23a or 28e-f ahow idical Examiner must be notified at	d by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dat	es:		1□Yes 🍹	K∐ No	Specify:			Spec	eify: B	lack
15-(n 72 h	iete	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 2th grade			16a. Deced	tent's Usual kind of work DO NOT use	l Occupa k done d	tion <i>uring</i> most	t of worki	ng	16b. Kind of	Business/ir	dustry
12	within iene. r than	duo	Elementary/Secondary (0-12) 2th grade	College (1-4	for 5+)		elety					Balto	Sun	Paper
DG.	be filed stal Hygi od other avant, I	Be C	17. Father's Name (First, Middle, Last,)							(First, Middle,		ame)	
ylaı	should be nd Mental n marked c	To	Matthew B. Fra						Pear	cl A	. Cla	rk ————		
Maryland 21215-0036	7 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		19a. Informant's Name/Relationship (Beverly Chrisia	• • • • • • • • • • • • • • • • • • • •							Route Numbe Winds			d 21244
	1 an Heali am 2 ther	1	20a. Method of Disposition	all-Daug	20b Plac	ce of Disno	sition (Nam	e of	1		ate	20c. Location		
E O	0 0		1 █ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		ale	netery, cren a Mei				11/	4/06	Randal	llsto	wn, MD
Baltimore,	permit. Pag Department Important: I any injury o		21. Significant of Funeral Service Licer		011	M 22	Name and	Aggres	WE'S	Ł				
	70 E # 9	2	primale (J. The	gut						Balti		Md	21215
		, J	3a. P.Int. Enter the disease, or com- nock, or heart failure. List only Impediate Cause (Final	one cause on eac	used the death, th line.	Do not ente	er the mode	of dying	such as	cardiac o	r respiratory ar -	rest,		Approximate Interval Between Onset and Death
	Physician /Medical		di ease or condition sulting in death)	a Due to (or	as a conseque	CC+ CO):	ory	N	nu	JEE				
	Examiner		Sequentially list conditions	h	FTA	STA	Dic	U	NG	d	HUGH			
	D is	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	s a conseque	nce (1):								
	xecut	Examine	that initiated events resulting in death) Last	c	as a conseque	nce of):								
8760,	death certificate be executed e ettending physicien and ad for use as the burial-transit	calE	(d										
9	ntificat ng phy as th	Physician/Medical	UF FERMALE.	<u> </u>										
Вох	death certifica ettending pt d for use as t	lan/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outco	ome of pregnanc h 2 🗌 Fetal de		Ectopic pre	gnancy					ate of deliver	ery Day Year
	he de	ysic	1 Yes 2 No 9 Unknown	4□Pregnar 9□ Unknow	nt at time of deat n	th 5 🗆	Other (spe	ecify)	-			,	noriti	Day
P.O.	law requires that the de as been signed by the E 2 should be detached t	by Ph	Part II. Other significant conditions of	ontributing to dea			nderlying ca	use give	n in Part I.		23e. Did to	obacco use co	ntribute to t	ne cause of death?
rds	w requires t been signe should be	ed b	RUMONE	Ley.	5MB	OUS	M				101	∕es 2XÍNo	3 🗌 Prot	ably 4 Unknown
ecc	e law re has be	Completed	GASTROIN	M IN	NITC	BUB	BN				24a. Was	an 24b	. Were auto	psy findings available mpletion of cause of
E R	Th pag	Con									perfo	med?	death? 1 ☐ Yes	≥ No
Zita	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical — examiner? 1 ☐ Yes 2 📉 o	Hospital:		2/0		Othe	-		Check only o			
0	g Physer this	\vdash	27. Manner of Death	1 Inp		VOutpatient 8b. Time of		c. Injury	at at		ne 5 6 esid 8d. Describe h			y)
sior	Attending in death.	atio	1 atural 5 Pending investigation	1	Day reary	Injury	м	Work 1 □ Y	es 2 🗆 î	No				
Division of Vital Records,	il or Attend after death Director: ,	Certification:	3 Suicide 6 Could not be determined	289. Place of	f Injury - At home , etc. <i>(Specify)</i>	e, farm, stre	eet, factory,	office		2	8f. Location (S City or Tow	Street and Nur vn, State)	nber or Rura	il Route Number,
_	o the Hospital or Attending ithin 24 hours after death. o the Funersi Director: After impletely filled in by the fune	<u>a</u>	29a. Certifier 1 Certifying Ph	ysician: To the b	est of my knowle	edge, death	occurred a	t the time	e, date and	d place, a	nd due to the	cause(s) and r	nanner as s	tated
	he Ho in 24 t he Fu pletely	edical	(Check only 2 Medical Examone)	niner: On the bas and manne	is or examination	n and/or inv	restigation,	in my op	inion, deat	th occurre	d at the time, o	date and place	, and due to	the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	· ·			29c.	License	number) (s		29d. Date sign	ed (Month,	Day, Year)
,	55		Y W UBOAU	12 W	<u>)</u>	20) /T	1	14	14:	5 Y		11/0	110	6
2	5 '		30. Name and address of person who	completed cause) Signation (Item 2)	оа) (туре, I С (TZ	2AV	7 8	· (.	RAI	N OR	S	2120
	Sta		31. Date filed (Month, Day, Year)	006 32 Fleg	istrar's Signatur	2 As	och 9	-				,		
7	Registr	ar	NOW O B ZL	JUU LA	2000 100	100	M. and Marriage							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene U 35146 Certificate of Death

Physicia /Medic Examin	al	4 3
Funeral Director		2
ס		L

Physic		talph	erou .	Sch	rader		Oc tobe	r 30°, 2	.00 ^{Year}	3:15 Рм
/Medi Examii		4a. Facility Name (If not institution, give	street and number)		1 - 101	or Location of Deat			nty of Death	1
Exami		3029 Lieb Road			Parkton			Balt	imore	
Funeral Director		214-20-3021	ex	ast birthday Yrs.) If Under 1 Year Months Days		8. Date of Bi (Month, Da NOV • 5	rth ay, <i>Year)</i> • 1926	9. Birthp Coun Penns	lace (State or Foreign sylvania
pus *		Usual Residence of Decedent 10a. State 10b. County	10c. Cib	, Town or L	ocation				1	0d. Inside City Limits
Aaryla Febo	5	MD Baltimor							1	1 □ Yes 2√□ No
138 the	rect	10e. Street and Number	C Tuit		10f. Zip Code			10g. Citizen o	of What Cour	ntry?
3a or		3029 Lieb Road			21120			USA		
gas 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Manial Hygiana. If Item 27 is marked other then "natural", or Items 23s or 28s-1 show or other treumatic event, the Medical Experiment must be nutitied at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Amed Forces? 1 [X] Yes 2 [☐ No If Yes, Give Year or Dates:	1	Was Decedent of h If Yes, specify Cub 1 ☐ Yes 2 No		pecify Yes or No o Rican, etc.)		ace - Americ lack, White, cify: Whi	etc.
72 ho	Completed	15. Decedent's Ed (Specify only highest gra		16a. Dece	edent's Usual Occup	pation during most of wor	rkina	16b. Kind of	Business/Inc	dustry
a dthin	혍	Elementary/Secondary (0-12)	College (1-4or 5+)		e kind of work done DO NOT use retire	d)	9	CAD		
o, wan yearlo Z.1.Z. 1 and 2 should be filed within Health and Manial Hygiana. iem 27 is marked other then other treumatic event, the Mania	ខ	17. Father's Name (First, Middle, Last)		Super	Visor	18. Mother's Nar	no (Eirot Middle	C&P Te		1e
ntai H	Be	Ray A. Schrader				Evelyn		, Maiden Sun	airie)	
should be nd Mantal o marked o	၉	19a. Informant's Name/Relationship (Type. Print)	19b Mail	ing Address (Street			er City or Tow	n State Zin	Code)
and 2 s aalth ar n 27 le	1 3	Michael Schrader	/ son		Lieb Road			-		
gas 1 and t of Haalth if Item 27 or other tr		20a. Method of Disposition	20b. P	lace of Disp	osition (Name of ematory or other pla	1	Date	20c. Location	n - City or To	wn, State
Pagas nant of I		1 ☑ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify	Hemovai from State	-	e Nationa		/06	Baltim	ore, N	1D
글 문문을 .		21. Signature of Fune al Service Vicer	see (2	2. Name and Addre	ess of Facility			0 York	
Dapa Impo	1	1 lety t	Clay	R	uck Tows	on Funera	1 Home	Tow	son, N	1D 21204
Filysician /Medical Examiner		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequence)	no 1	nter the mode of dying		or respiratory a	ırrest,		Approximate Interval Between Onset and Death
	Ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequ	uence of):						
rtad J Insit	틭	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								
ata ba exaci nysician and ha burial-tre	Ical Examiner	that initiated events resulting in death) Last	c. Due to (or as a consequence d.	ience of):						
ras that the death certificate be exacuted ras that the death certificate be exacuted igned by the attending physician and be detached for use as the burial-transit	hysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	death 3	□Ectopic pregnanc	y		1	Date of delive Month	ry Day Year
quiras that n signad t	by P	Part II. Other significant conditions of Hementia	ontributing to death but not rest	ulting in the t	underlying cause giv	ven in Part I.	23e. Did 1	- i/		e cause of death? ably 4 \(\sum \text{Unknown} \)
ne law rac n has bea ga 2 shor	Completed	Decusition	whois			· · · · · · · · · · · · · · · · · · ·	24a. Was auto perfo	an 24b psy prmed2	o. Were autop prior to con death?	osy findings available npletion of cause of
in: Ti	S	25. Was case referred to medical				Of Place of Dec	1 Yes	2 🗷 No	1 🗆 Yes	2□ No
ysicia s cart	0 8	examiner?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outnatie	nt 3□ DOA Ott	26. Place of Dea	ome 5 / Resi		ther (Specific	·)
ding Phy I. Aftar thii funaral c	D: Ho	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	of 28c. Injui Wo	ry at rk?	28d. Describe			/
iospital or Attending Physicien: The law raquiras that the thours aftar death. Linous aftar death. Linous aftar death. Linous aftar death. Linous aftar death. Linous aftar death. Linous aftar death.	Certificati	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		me, farm, st		Yes 2 □ No	281. Location (City or To		nber or Rura	l Route Number,
lospii L hour unera	cai (29a. Certifier 1 Certifying Ph	ysician: To the best of my kno- niner: On the basis of examina	wledge, dear	th occurred at the time	me, date and place	, and due to the	cause(s) and r	manner as st	ated.

State Registrar

DHMH 17 Rev 1/2001

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number 030433 29d. Date signed (Month, Day, Year)

NOV 1 , 2006

Baltimore Ma 21204

. , , , , , , , , , , , , , , , , , , ,	Didok ilidelibie	, IIII. E110G	TO All OUP	ILO AICE	-221	Y IS
State of Mary	land / Departmen	t of Health a	and Mental	Hygiene	UL	J E

			1 - For State Registrar		aryland / De	partr <i>ertifi</i>	ment icate	of H	ealth a	and M	lental Hygie	né	006	35147
П	Physici	an	1. Decedent's Name <i>(First, Middl</i> e, Las Kathryn E.	_{t)} Stidm	nan						2. Date of Death Month	Day		3. Time of Death
	/Medio		4a. Facility Name (If not institution, give			4b.	. City, T	own, or	Location o	f Death	November		, 2006 County of Dea	3:00 p M
	LAdilli		Manor Care-Ruxto	٦			_	າພຣວາ					Balti	
	Funeral Director		5. Social Security Number 6. Social Security Number 1 1 216-03-4545	9x □ M 2	e (In yrs. last birthd 90 Yrs	Mo	Under 1	Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth April 12	ear),	^{9. Ві} 1916 Ма	nthplace (State or Foreign ountry) ITYLand
	yiand Now		10a. State 10b. County		10c. City, Town o	r Locatio	on							10d. Inside City Limits
	e Mar Sa-fat	ctor	MD Bai	Ltimore	Tows	חכ								1 ☐ Yes 2√ No
	with th	Dire	10e. Street and Number 505 Holden Road			10	0f. Zip (286			10g	. Citi	zen of What C	
	death ms 23	erai	11. Marital Status	12. Was Decedent	Ever in U.S.	13. Was			panic Orio	gin? (Spe	ecify Yes or No-	1	14. Race - Am	
36	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f ahow he Medical Exeminar must be notified at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3XI Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:	No		s, specif Yes 2		, Mexican Specify:	Puèrto	ecify Yes or No- Rican, etc.)		Black, Whi	
2-0	72 hou	ted	15. Decedent's Ed (Specify only highest gra	ucation	16a. Do	ecedent's	s Usual	Occupa	tion	of worki	16	b. Ki	nd of Business	/Industry
2121	ed within giene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5		lomer			iring most	OF WORK	ng		Օար հ	ome
/land	uld be file Mental Hy Irked oth	To Be (17. Father's Name <i>(First, Middle, Last)</i> John J.	Grimes						r's Name lian	(First, Middle, Ma	iden	Sumame) Dorn	
Mar	od 2 sho ith and 27 is mu		19a. Informant's Name/Relationship (7 Bruce R. Kurlande								I Route Number, C			Zip Code) 21044
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural", or items 23s or 28s-f ahow any fajury or other traumatic avent, the Medical Examinat must be notified at once.		20a. Method of Disposition 1 XBurial 2 Cremation 3 4 Donation 5 Other (Specify		20b. Place of Di cemetery, Morelar	sposition cremator	n (Name ry or oth	of er place)	0	ate 20	c. Lo	cation - City or Ltimore	
Balti	permit. Departmit. Importa any Inju		21. Signature of Funeral Service Licen		G. Dau	22. Nar	me and	Address	of Facility	Ruc Tow	k Towson son, MD		ineral 204	Home, Inc.
8760,	Physician /Medical Examiner but side paragraph of the private provided and private pri	ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (or as	a consequence of):		ot	e	<u>Ca</u>	rdu	ovascula		Diseo	Onset and Death
.O. Box 68	To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 54 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 MNo 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 □Ecto 5 □ Othe						2	23d. Date of de Month	livery Day Year
Ω.	uires that n signed by lid be deta	ρ	Part II. Other significant conditions of	entributing to death be	ut not resulting in th	e underly	lying cau	ise giver	in Part I.		23e. Did tobac			o the cause of death?
tal Records,	in: The law recilicate has bee	e Completed	octal be clehydra 25. Was case referred to medical	leedi ² ien	ne.				00.0	(0.4	24a. Was an autopsy performed 1 Yes 2	? No	prior to death?	utopsy findings available completion of cause of 2 No
<u> </u>	Physician: rthis certifica ral director, p	0	examiner?	Hospital:	nt 2 🗆 ER/Outpa	tient 3[□ DOA	Othor			Check only one ne 5□ Residenc	e 6	Other (Spe	ocify)
Division of Vital	Attanding Ph ir death. ector: After th by the funeral	ation; T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da)	y 28b. Tim Year) Inju			: Injury : Work?	at	2	28d. Describe how			
Divis	al or Atta s after de il Directo ed in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc	ury - At home, farm, c. (Specify)	street, fa	factory,	office		2	28f. Location (Stree City or Town, S			ural Route Number,
	the Hospital tin 24 hours a the Funeral theitely filled	edical (29a. Certifier (Check only one) Certifying Phyone	rsician: To the best of iner: On the basis of and manner sta	examination and/o	eath occi	curred at gation, in	the time	, date and nion, deat!	place, a	and due to the caused at the time, date	e(s) and	and manner as place, and due	s stated. e to the cause(s)
)	To the within 2 To the complet	×	29b. Signature and title of certifier	C Fael	Pen		29c.	License	number 56	4,2	29d.	Date	signed (Mont	2001
7	Sta Registr	te	30. Name and address of person who of the state of the st	aulkno	eath (Item 23a) (Ty	e, Print)		J,(cha	unf	street	- 4	Balt	DWD 5134
	negistr	aı	- 7 0 0 0	1 3 3 3 3 3 3	N 15 1	1	- Color							

			For State Registrar	State of Maryla	and / Department of H	ealth and Mental H Death	ygien 2063	5148
	Physici	an	1. Decedent's Name (First, Middle, Last) i=	Time	2. Date of D Month	Death 3	. Time of Death
	/Medi	cal	JOSEPHINE 4a. Facility Name (If not institution, give	street and number)	10 POPER	Leasting of Doub	01 06	1.40 PM
	Examir Funeral	ner	Chapel Hill A 5. Social Security Number 6. Se	lursing Cer	Ab. City, Town, or RANGO	allstown	Birth 0 Birthplace	RC (State or Foreign
	Director		214-14-032110 Usual Residence of Decedent]M 2004	Yrs. Months Days	Hours Min. (Monin, 8	1915 Mary	land
1	f ehow	or	10a. State 10b. County MD Carr	•	City, Town or Location Sykesvi	110		Inside City Limits 1 ☐ Yes 2 ☐ No
1 1	or 28a	Funeral Director	10e. Street and Number		10f. Zip Code	110	10g. Citizen of What Country?	Λ
4	9 2 3 8 Thurst	erai	5732 Greenville Ro		217		USA	
1215-0036	point. Tages I tails a should be find within 72 floors after death with the marytal benefit and the lith and Mental Hygione. Importent: If item 27 is marked other than "natural", or iteme 23a or 28a-f ehow any injury or other treumatic event, the Medical Examinat must be notified at once.	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 【Xi Widowed 4 □ □ivorced	12. Was Decedent Ever in Armed Forces? 1 Yes 24 No If Yes, Give Year or Dates:		spanic Origin? (Specify Yes or N I, Mexican, Puerto Rican, etc.) Specify:	14. Race - American I Black, White, etc. Specify: Whi	·
21215-0036	than "nat	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupa (Give kind of work done di life. DO NOT use retired)	uring most of working	16b. Kind of Business/Industr	ry
92	Hygie ther t		17. Father's Name (First, Middle, Last)		Housekeeper	18. Mother's Name (First, Middle	Health Care	
Maryland	ic eve	To Be	Louis Kelm			Cecelia Crov		
ary	and N s mar		19a. Informant's Name/Relationship (T)	, . ,	19b. Mailing Address (Street a		ber, City or Town, State, Zip Cod	de)
Z ;	m 27 I		Mrs. Dolores Myers		5939 Oakland Ro			
Baltimore,	ant of H		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	lamaval from State	. Place of Disposition (Name of cometery, crematory or other place vergreen Mem Gard	Date 11/6/06	20c. Location - City or Town,	State
뺿	oartme sorten / injur		21. Signature of Funeral Service Licens				Finksburg, MD	
<u>~</u>	Depa Impo any ir		Buar Lig	Hayy	Sykesville	e, MD 21/84 (41		95)
\$			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final	ications (ha) caused the de ne cause of each line.				oroximate erval Between set and Death
	hysician /Medical		disease or condition resulting in death)	Due to (or as a conse	idio fulmona	ry Arrest		
Ε	xaminer		Sequentially list conditions,	Coronan	y Artery DISC	y Arrost		
, to	insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consi	equence of):			
8760,	physicien and the burial-transit		that initiated events resulting in death) Last	Due to (or as a conse	equence of):			
		dicai		1				
Box 6	attending p	00	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of preg			23d. Date of delivery	
O. 1	, 42	Physician/M	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown			Month Day	Year
o.	signed by the a d be detached t	y Ph	Part II. Other significant conditions cor	itributing to death but not re	esulting in the underlying cause giver	n in Part I. 23e. Did	tobacco use contribute to the ca	use of death?
rds,	been sign	0					Yes 2 No 3 Probably	4 Onknown
Records, P.O	has be	Completed				24a. Wa:		indings available
a H						perf 1 ☐ Yes	ormed? death? 2√No 1 ☐ Yes 2√Z	/
of Vita	ois certifice director, p	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 ☐ Inpatient 2 [Other	26. Place of Death / Check only	- W	
ין סר היקים הי	= 65	\vdash	27. Manner of Death	28a. Date of Injury (Month, Day Year)	☐ ER/Outpatient 3☐ DOA 28c. Injury 28c.	4 Nursing Home 5 Res	how injury occurred	
Vision	death. ctor: Af the tur	catlo	1 Matural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		M 1 □ Ye	es 2 □No		
_ >	9 = -	Certification:	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, street, factory, office city)	28f. Location City or To	(Street and Number or Rural Rou own, State)	ute Number,
Hospite	within 24 hours after death. To the Funerel Director: A completely filled in by the tu	edical C	29a. Certifier (Check only one) 1 Certifying Phys	sician: To the best of my kner: On the basis of examinand manner stated.	nowledge, death occurred at the time nation and/or investigation, in my opin	, date and place, and due to the nion, death occurred at the time,	cause(s) and manner as stated, date and place, and due to the	cause(s)
To the	within 2 To the	Me	29b. Signature and title of certifier	State of the state	29c. License		29d. Date signed (Month, Day,	Year)
^	1		Muller	er	114	5931	November 3 Baltimore	2006
12			30. Name and address of perso who do	pleted cause of death (Ite	om 23a) (Type, Print)	12/21/2011/2	Roll Inone	112
			$-\nu_{\odot}\nu_{\odot}\nu_{\odot}\nu_{\odot}\nu_{\odot}=10$	010 111	() (() () () () ()			ハハノウロル
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign	lature	for verue	GCI CHOUSE	MU2124
DHML	Sta Registra	ar	31. Date filed (Month, Day, Year)	32. Registrar's Sign	lature	inverie	THE COUNTY E	MU 2124

				d Mental Hygien	Δ .
			State of Maryland / Department of Health and 1- State Amend #26, perMD, 6861,11/6/06 TT Certificate of Death	Reg. N	2006 25110
			Decedent's Name (First, Middle, Last)	2. Date of Death	3. Time of Death
	Physici /Medic		ANGELA THOMPSON	_	19 2006 12:55 M
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of De	eath 4	c. County of Death
			THE THUS HOPKINS HOSPITAL BALTIMORS 5 Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 H	CITY	NIA
	Funeral Director			lin. 8. Date of Birth (Month, Day, Year	9. Birthplace (State or Foreign Country)
	JII COTOI		Usual Residence of Decedent	1901, 29.11	31 10
ırylan	whow H H	Ļ	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits 1 1 Yes 2 □ No
he M	28a-f	ecto	10e, Street and Number 10f, Zip Code	140- 0	
death with the Maryland	"natural", or iteme 23e or 28e-f ehow exical Extrumer Lural be netified at	Funeral Director	30 6 N. Robinson St 21224		itizen of What Country?
death	me 23	era	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin?		SA 14. Race · American Indian,
after O	or ite	Fu	Armed Forces? If Yes, specify Cuban, Mexican, Pu I Yes, Sive If Yes, specify Cuban, Mexican, Pu I Yes, Sive I Yes 2 No I Yes 2 No Specify:	Jeno Hican, etc.)	Black, White, etc. Specify: Rlack
5-UU36 72 hours after	Exa	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		Mack
n R	"nat	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of will be DO NOT use retired)	working 16b. I	Kind of Business/Industry
within	than than	d wo	Elementary/Secondary (0-12) College (1-4or 5+)		Seif Employed
ם פון	othe vent,	Bec		Name (First, Middle, Maide	
and bu	Menta arked atic e	To	Voseph L. Thompson Norm	ia Jean L	lampton
Mar d 2 sho	th and Men 7 is marke traumatic		19a. Informant's Name/Relationship (Type, Print)	Rural Route Number, City	or Town, State, Zip Code)
1 and	f Health item 27 other t		20a. Method of Disposition 20b. Place of Disposition (Name of	Baltimore 200.1	Ocation - City or Town, State
Pages	_ = p		Burial 2 Cremation 3 Removal from State	10/00/01	A A
Saltimor Dermit. Pages	Departmentimportent: any injury once.		4 □Donation 5 □Other (Specify) 171N1+y (emetery) 21. Signature of Experal Service Licensee/ 22. Name and Address of Facility (Chatman-H	arris Funeral Home
ם פֿ	on in g	l. is	Sun Jana 5240 heistersto	ow Bd Ba	
		(23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shoet, or heart failure. List only one cause on each line.		Approximate Interval Between
Ph	ysician	_	disease or condition Sta. 4 Ade. C	uma ha	Onset and Death
	Medical caminer		resulting in death) Due to (or as a consequence of):		7011.05
	3	70	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):		
uted	ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events		
oxec	ysicien and ie burial-transit		resulting in death) Last Due to (or as a consequence of):		
. BOX 68/60, death certificate be executed	nysicie he bu	lcal	d		
X 08	ding pl	Med	IF FEMALE:		
BOX Bath ce	attend for us	ian	23b. Was decedent pregnant in the past 12 pronths? 1 Yes 2 No 2 Holesons	Î	23d. Date of delivery Month Day Year
j 🖁	y the	ysic	1 ☐ Yes 2 MNo 9 ☐ Unknown 9 ☐ Unknown		
	ned b e deta	by Physician/Med	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
s that	S 0				
ords, P	6 J	ed		1 ☐ Yes 2	! □No 3 □ Probably 4 Unknown
OrdS, I	as been signed by the attending phys 2 should be detached for use es the	pleted		24a. Was an	24b. Were autopsy findings available
The law	ete has page 2	Completed		440	24b. Were autopsy findings available prior to completion of cause of death?
The law	ete has page 2	BeC	examiner?	24a. Was an autopsy performed? 1 □ Yes 2 LXN	24b. Were autopsy findings available prior to completion of cause of death?
r Vital Rec ysician: The law	is certificete has director, page 2	To Be C	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 OA Other: 4 Nursing	24a. Was an autopsy performed? 1 Ves 2 XN	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 21 No
r Vital Rec ysician: The law	is certificete has director, page 2	To Be C	examiner? 1	24a. Was an autopsy performed? 1 □ Yes 2 LXN	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 21 No
r Vital Rec ysician: The law	is certificete has director, page 2	To Be C	examiner? 1	24a. Was an autopsy performed? 1 Ves 2 N Death Check only or 28d. escribe how inju	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 21 No 6 Other (Specify) and Number or Rural Route Number,
r Vital Rec ysician: The law	is certificete has director, page 2	Certification; To Be C	examiner? 1	24a. Was an autopsy performed? 1 Ves 2 N Death Check only of 1 g Home 28d. escribe how injuited a City or Town, State	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2) No 6 Other (Specify) ury occurred and Number or Rural Route Number, e)
r Vital Rec ysician: The law	is certificete has director, page 2	Certification; To Be C	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 NOA Other: 4 Nursing 27. Mayfier of ath 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 1 Yes 2 No 28c. Place of Injury - At home, farm, street, factory, office 28a. Place of Injury - At home, farm, street, factory, office	24a. Was an autopsy performed? 1 Yes 2 N Death (Check only or) 9 Home 28d. escribe how injuted ace, and due to the cause(sace, and due to the cause(s	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 6 Other (Specify) any occurred and Number or Rural Route Number, e)
r Vital Mec ysician: The law	is certificete has director, page 2	To Be C	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3XTOA Other: 4 Nursing 27. Mayfier of light Natural 5 Pending investigation 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier (Check only one) Check only one)	24a. Was an autopsy performed? 1 Ves 2 L N Death (Check only or) g Home 28d. escribe how into a city or Town, State ace, and due to the cause(securred at the time, date and coursed state and coursed state and state and state are state and state and state are state and state are state and state are state and state are state and state are state and state are state and state are state and state are state and state are state and state are state and state are state are state and state are state and state are state and state are state are state and state are state are state and state are state are state and state are sta	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 6 Other (Specify) any occurred and Number or Rural Route Number, e)
r Vital Mec ysician: The law	certificete has rector, page 2	edical Certification; To Be C	examiner? 1	24a. Was an autopsy performed? 1 Ves 2 N Death Check only or 28d. escribe how injuted 28f. Location (Street a City or Town, State ace, and due to the cause(securred at the time, date and 29d. December 29d. Decemb	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 21 No 6 Other (Specify) 1 yo occurred 1 And Number or Rural Route Number. 1 And number or Rural Route Number. 1 And number or Rural Route Number. 1 And number or Rural Route Number. 1 And number or Rural Route Number. 1 And number or Rural Route Number. 1 And number or Rural Route Number. 1 And number or Rural Route Number. 1 And number or Rural Route Number. 1 And number or Rural Route Number. 1 And number or Rural Route Number. 1 And number or Rural Route Number.
r Vital Mec ysician: The law	is certificete has director, page 2	edical Certification; To Be C	examiner? 1	24a. Was an autopsy performed? 1 Ves 2 N Death Check only or 28d. escribe how injuted 28f. Location (Street a City or Town, State ace, and due to the cause(securred at the time, date and 29d. December 29d. Decemb	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 21 No 6 Other (Specify) 1 yo occurred 1 And Number or Rural Route Number. 1 And number or Rural Route Number. 1 And number or Rural Route Number. 1 And number or Rural Route Number. 1 And number or Rural Route Number. 1 And number or Rural Route Number. 1 And number or Rural Route Number. 1 And number or Rural Route Number. 1 And number or Rural Route Number. 1 And number or Rural Route Number. 1 And number or Rural Route Number. 1 And number or Rural Route Number.
r Vital Mec ysician: The law	is certificete has director, page 2	edical Certification; To Be C	examiner? 1	24a. Was an autopsy performed? 1 Ves 2 N Death Check only or 28d. escribe how injuted 28f. Location (Street a City or Town, State ace, and due to the cause(securred at the time, date and 29d. December 29d. Decemb	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 6 Other (Specify) any occurred and Number or Rural Route Number. e) s) and manner as stated. d place, and due to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician NOVEMBER 2006 12:35 PM 2, LEE PETERSON TOPPING HAZEL /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY HOLY CROSS HOSPITAL SILVER SPRING 8. Date of Birth (Month, Day, MAY 3, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours NORTH CAROLINA 1 □ M 2 🕅 F 73 Director 065-28-0066 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at anotes. 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State 1 ☑ Yes 2 ☐ No Director MARYLAND PRINCE GEORGE'S HYATTSVILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20782 6313 BALFOUR DRIVE U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: BLACK ģ 3 ☐ Widowed 4 ₺ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) D.C. DEPARTMENT OF Elementary/Secondary (0-12) College (1-4or 5+) ACCOUNTANT TECHNICIAN CORRECTIONS 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LUVINA MERRICK CHARLIE PETERSON, SR. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 14109 SILVER TEAL WAY, UPPER MARLBORO, MD 20774 SHARON HUGHEY (DAUGHTER) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 11/11/2006 WASHINGTON, NC 5 Other (Specify) CEDAR HILL CEMETERY 21. Signature of Funeral Service Lice vee 22. Name and Address of Facility
RANDOLPH FUNERAL HOME MARICE 219 N. BONNER ST., WASHINGTON, NC 27889 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ACUTE RENAL FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospitai or Attending Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) P.O. Box 68760, Physician/Medical the IF FEMALE: asn If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Be Completed by 2 No 3 Probably 4 Unknown 1 TYes page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1X Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident death hours after deatl uneral Director; 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1\(\) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 \(\) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated within 2 Date signed (Month, Day, Year) 29b. Signature and

State Registrar 30. Name and ad

31. Date filed (Month, Day,

Year)

06

nnleted cause of death (Item 23a) (Type

32. Registrar's Signature

		For State Registrar	State of Mary		artment of rtificate o		and Me		ene g. No.2 (106	35151
Physicia		Decedent's Name (First, Middle, Last) Alva	Virgini	ia	Wiley			2. Date of Death	_	:0Ŏ6°	3. Time of Death 11:30a M
/Medic Examin		4a. Facility Name (If not institution, give s 1530 Windermere			4b. City, Town	or Location of			4c. Coun	ty of Death NA	
Funeral Director		5. Social Security Number 6. Sex 577–62–5576	M 25 F	yrs. last birthday) Yrs.	If Under 1 Ye Months Day		24 Hrs. Min.	8. Date of Birth (Month, Day,		9. Birthp	place (State or Foreign ptry)
land ow		Usual Residence of Decedent 10a. State 10b. County		c. City, Town or L	ocation					1	0d. Inside City Limits
h the Maryland r 28a-f show	Director	Md. NA		Balti							1 XYes 2 No
3a or 2		10e. Street and Number 1530 Windermere	Avenue		10f. Zip Cod 2.	1218		10	g. Citizen o	What Cour USA	ntry?
72 hours after death with the Maryland naturel; or Items 23a or 28a-f show acal Examinat must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Note: Married 2 Note: Married 2 Note: Married 2 Note:	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	r in U.S. 13.	Was Decedent of If Yes, specify 0		gin? (Spec	offy Yes or No- Rican, etc.)		ace - Americ ack, White, ify: Bla	etc.
⊆ .	Completed t	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation	16a. Dece (Give	dent's Usual Oc kind of work do DO NOT use re	cupation ne during mos ired)	t of workin	g 1	6b. Kind of		
2 should be filed within and Mental Hygiene. is marked other than "eumatic event, the Men	Be Con	17. Father's Name (First, Middle, Last)		СО	ok/manag	ger 18. Mothe	er's Name	(First, Middle, M			e Universit
d 2 should be filed th and Mental Hyg ?? is marked othe treumatic event,	ဥ	Norfleet 19a. Informant's Name/Relationship (Ty)		ore	ing Address (Str		hel er or Rural	Route Number,		Allen n, State, Zip	Code)
コピト		Kattina Jones-dau	ghter					e Balti			21218
permit. Pages 1 and Department of Healt Important: if Item 2 eny Injury or other 2 once.		20a. Method of Disposition A Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)		20b. Place of Disp cemetery, cre Forest	osition (Name of matory or other Lawn Cel	olace)		5/2006	0c. Location Empo		own, State MD
permit. Departr Importa eny inju		21. Signature of Funeral Service License	hltra	2	2. Name and Ad 1101 E.		. 1.1	arch F.I , Baltin			21202
Physician /Medical Examiner uysicien and phe parial-transit	ical Examiner	dispasse or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Dispasse or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence of):							pre gant
to the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours effer death. To the Funerel Director: After this certificete has been signed by the attending physicien and completely filted in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	□Ectopic pregna □ Other (specify					ate of delive	ery Day Year
quires thet n signed b ald be deta	ξ	Part II. Other significant conditions cor	tributing to death but no	ot resulting in the t	underlying cause	given in Part I		23e. Did tob	\		ne cause of death?
The law requir sete hes been si page 2 should	Completed							24a. Was an autopsy perform	_	. Were auto prior to co death? 1 \(\text{Yes} \)	psy findings available mpletion of cause of 2 No
ysiclen: Th is certificete director, pag	o Be	25. Was case referred to medical examiner?	lospital:	2 ER/Outpatie	nt 3□ DDA	Other		(Check only one	•	ther (Specif	v)
inding Physath. ath. r: After this ie funeral di	ation: T	27. Manner of Death 1 Selatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	28b. Time o	of 28c. 1	njury at Vork?	2	8d. Describe ho			
To the Hospitel or Attendinin 24 hours effer death. To the Funerel Director: A completely filted in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (5	Specify)				City or Town	State)		i Route Number,
To the Hospitel within 24 hours etgo the Funerel Completely filled	edical	29a. Certifier 1 Sertifying Physical (Check only one) 2 Medical Exami	sician: To the best of m ner: On the basis of exa and manner stated	amination and/or i	th occurred at the overtigation, in n	e time, date an ly opinion, dea	nd place, a ath occurre	nd due to the ca d at the time, da	use(s) and r te and place	nanner as s e, and due to	tated. o the cause(s)
To the within To the complex	Me	29b. Signature and title of certifier Room	Carlor	m	λ	anse number	20		d. Date sign	06	
5		30. Name and address of person who co	1 White	mark	Print) 492	Larr	ple	el 3/20	I, wh	法が	nart, MU
Sta Regist		31. Date filed (Month, Day, Year) NOV 0 6 201	32. Gegistrar's	Signature	souls						

			1 - For State Registrar	State of Mar		artment of F			giene	6 35152
	Disconini		1. Decedent's Name (First, Middle, Las	it)				2. Date of De Month	ath	3. Time of Death
	Physici /Medic		HENRY LOUIS WILSO			1		CC 7000	R. 3100	16 7:05 MM
	Examin	er	4a. Fecility Name (If not institution, give			4b. City, Town, or	r Location of De てフィ州		4c. County of E	Death
	E		5. Social Security Number 6. Se	EXUOUD 7. Age	(In yrs. last birthday)	If Under 1 Year	If Under 24 h	rs. 8. Date of Birt	th 9.	Birthplace (State or Foreign
	Funeral Director			MM 2□F	90 Yrs.	Months Days	Hours N	fin. (Month, Da 08/29	y, Year)	Country) MD
	pu ,		Usual Residence of Decedent		10c. City, Town or Lo					10d. Inside City Limits
	shov	ū			,,					1 Ves 2 No
	28a-1	Director	MD 10e. Street and Number		BALTIMORE	10f. Zip Code			10g. Citizen of Wha	t Country?
	3a or		1204 N. MILTON A	VE		21213			USA	
	death	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 13.		lispanic Origin?	' (Specify Yes or No uerto Rican, etc.)		American Indian, White, etc.
36	or It	by Fu	1 Never Married 2 Married	1 XYes 2 □ No If Yes, Give)	1 ☐ Yes 2 🔀 No	Specify:	,	Specify:	
5-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-1 show tha Maical Exciniter must be coaffied at	ed b	3 ☐ Widowed 4 💆 Divorced 15. Decedent's Ed	Year or Dates:	16a Dece	dent's Usual Occup	ation		16b. Kind of Busin	
5	nin 72 Bu'' ni	Completed	(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of	working	700. [(110 01 0001)	ood maddily
212	ad with giene er tha	Com	1 OTH			RTILIZER			FACTORY	7
Maryland 2121	be filed stal Hygid of other event.	Be	17. Father's Name (First, Middle, Last)				18. Mother's I	Name (First, Middle,	Maiden Sumame)	
Z	should I	2	THOMAS WILSON 19a. Informant's Name/Relationship (7)	Tuno Print)	10h Maili	na Addroon /Street		STEWART	er, City or Town, Sta	to Zin Codel
Ma	and 2 sl ealth an n 27 Is r		SHIRLEY OWENS/DAU						ar investor	
ē,	s 1 ar f Hea item other		20a. Method of Disposition		20b. Place of Dispo	osition (Name of matory or other place		BALTIM Date	20c. Location - City	y or Town, State
altimore,	Pages nent of int: If it iry or o		1 X Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specify		CROWNS			/06/2006	CROWNSV]	TLLE. MD
Balti	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event. The Modical Examiner must be conflicted at ORCe.		21. Signature of Funeral Service Licen	see/		2. Name and Addres			AVIS, JR.	
	205 a g		Washing 6	newsp		2007-09	EASTER	AVE., B	ALTIMORE,	In color
			23a. Pail 1. Enter the disease, a comp shock, or heart failure. List only of Immediate Cause (Final	olications that cause of the		er the mode of dyin	ig, such as card	diac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician / /Medical		disease or condition resulting in death)		consequence of):	1+CA-LT	FAIL	-11 Ri-		
	Examiner				NARY	ARTER	y Dis	2ATC		
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		consequence of):	,	1 0/30	2011 62		
	ecuted and -trans	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.						1
8760,	be executed sician and burial-transit	al E	1 day 1 day	Due to (or as a	consequence of):					
687	et Sy	edical	•	d						
Вох	leath certifica attending ph I for use as th	Physiclan/Me	23b. was decedent pregnant	23c. If yes, outcome of 1□Live birth 2		Ectopic pregnancy	,		23d. Date of	
	e deat he attr	sicla	in the past 12 months?	4☐Pregnant at til		Other (specify)			Month	Day Year
P.0	that the de led by the a detached f		9 Unknown Part II. Other significent conditions or		not reculting in the u	nderhing cause giv	on in Part I	23e Did to	obacco use contribut	te to the cause of death?
ds,	uires tha signed d be det	d by	Part II. Other significent conditions of	onthibuting to death but	not resulting in the d	ndenying cause giv	en in Fait i.		Yes 2□No 3□	
COL	w require been si should	lete						24a. Was	an 24b Wer	e autopsy findings available
Be	The tav	Completed						autor perfo	osy prior deat	to completion of cause of h?
ita	ician: Th certificate rector, pag	O	25. Was case referred to medical				26. Place of I	1 Tes Death (Check only o		165 2 140
<u>_</u>	d is	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient			4 Usarsin	g Home 5 ☐ Resid	dence 6 Other (Specify)
Division of Vital Records,	Attending Physician: r death. ector: After this certifics by the funeral director. I	lon:	27. Manner of Death 1	28a. Date of Injury (Month, Day	Year) 28b. Time o	Wor		28d. Describe h	now injury occurred	
Si	or Attendater death Director:	ficat	2 Accident investigation 3 Suicide 6 Could not be	.	y - At home, farm, sti		Yes 2 □ No	28f. Location (S	Street and Number o	r Rural Route Number,
<u>S</u> .	i Site	Certification:	4 Homicide	building, etc.				City or Tov		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier 1 Certifying Ph	ysician: To the best of niner: On the basis of e	my knowledge, deat	h occurred at the time	ne, date and pla	ace, and due to the	cause(s) and manne	r as stated.
	the H hin 24 the F mplete	Medi	one)	and manner state	ed.					
	wit To To		255. Signature and tide of Certifier	ATTENDIA	4 PHYSIC	DC	0620	139,	NO COMA	R 1 2001
	4		30. Name and address of person who	completed cause of dea	ath (Item 23a) (Type:	Print) Inton	- 0000	CON CA	14 CAN	Cart
_	Ψ		6000	BELLO	np 1	AU B	BAL	7 INOLE,	IE am	616
	Sta Registr		30. Name and address of person who a GOOO 31. Date filed (Month, Day, Year)	32. degistrar	's Signature	ed)				

State of Maryland / Department of Health and Mental Hygien & UU6

For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) November 4, 2006 **Physician** Stuart Aumann 9:45P Susan /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Good Samaritan Nursing Home Baltimore N/A 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yrs. Months Days Hours Min. January 10, 1954 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1 M 2/X Maryland 214-74-9679 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-1 ahow ss i and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-1 ahov other traumatic avant, the Medical Examinal must be notified at 1XXYes 2 □ No Director N/A Baltimore Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1601 East Belvedere Avenue 21239 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXINo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes XX No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Admissions <u>Hospital</u> 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Robert Albert Aumann Virginia Morrow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tracy Aumann Foley Sister 2390 69th Avenue South, St Petersburg FL 33712 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 □ Burial XX Cremation 3 □ Removal from State Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Importent: If Itel
any injury or oth GreenMount Crematory 11/7/06 Baltimore, Maryland 4. □Donation 5 □Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Fun. Hom Inc 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) TRACT 2 WEEKS **Physician** URINARY /Medical Due to (or as a consequence of): Examiner **VEYKS** GUADRAP LEGIA 10 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit YBARS SCLEROSIS MULTIPLE that initiated events resulting in death) Last and Due to (or as a consequence of): of Vital Records, P.O. Box 68760, the attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth in the past 12 months? 2 Fetat death Month Day Year 4 Pregnant at time of death 5 Other (specify) detached his certificate has been signed by director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 No this certificate Attending Physician: 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Medical Certification: To 1 🗌 Yes 2 ER/Outpatient 3□ DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury ivision 5 Pending М 1 ☐ Yes 2 ☐ No investigation 2 Accident the Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funerel Dire 0 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (ompletely (Check only one) To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 11/06/2006 D28987 30. Name and address of person w o completed cause of death (Item 23a) (Type, Print) BALTO, MD RAVEN BLUP CARL SPERLING, MD 5601 LOGH 31. Date filed (Month, Day, Year) 3. Registrar's Signature State NOV 0 8 2006 Registrar

			1 - For Stata Registrar	State of Marylan	d / Depa <i>Cei</i>	artment of tificate o	Health and I f Death		Reg. No.	006	
	Physici		1. Decedent's Name (First, Middle, La BETTY		ZINGTO	N		2. Date of De Month Novemb	Day	2006	3. Time of Death 8:05 A M
	/Medio		4a. Facility Name (If not institution, given JOHNS HOPKINS B	AYVIEW MEDICAL	CENTER	4b. City, Town	n, or Location of Death	1	4c. Cou	inty of Death	
ŀ	Funeral Director		5. Social Security Number 6. S 234-26-5731 Usual Residence of Decedent	Sex 7. Age (In yrs. 1 ☐ M 2 ☐ F 86	last birthday) Yrs.	tf Under 1 Ye Months Day		8. Date of Bird (Month, Da	y, Year)	Cour	place (State or Foreign htry)
	ryland how		10a. State 10b. County		y, Town or Lo					1	10d. Inside City Limits
	he Ma	Director	Md. Bali	timore	Dun	dalk			10a Citizon	of What Cour	1 ☐ Yes 2 No
	3a or 2	i Dir	1953 Merritt	Blvd.		10f. Zip Cod	21222			USA	ntry !
936	n 72 hours after death with the Maryland "natural", or Itams 23a or 28a-f show alical Examination must be notified at	by Funeral	11. Maritat Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:	1	Was Decedent of Yes, specify C	of Hispanic Origin? (Suban, Mexican, Puerl No Specify:	pecify Yes or No o Rican, etc.)		Race - Americ Black, White, ecify: Wh:	etc.
215-0036	22 8 3	eted	15. Decedent's E (Specify only highest gro	ducation ade completed)	(Give	dent's Usual Ockind of work do	ne during most of wor	rking	16b. Kind o	of Business/In	dustry
_	within ane. then	Completed	Elementary/Secondary (0-12) 12 yrs.	College (1-4or 5+) 2 yrs.	life. i	DO NOT use rea Hou	_{ired)} sewife		j	Home	
and	be filed ntal Hygid od other svsnt, I	BeC	17. Father's Name (First, Middle, Last)				me (First, Middle,			
	should Ind Ment	၉	Ray Wesley Wa		19h Mailir	na Address (Stre	Aman eet and Number or Ru	da McGe			Code
Mary	nd 2 alth a 27 to		John C. Arring				ritt Blv		•		
altimore,	Pages 1 a ent of Hei nt: If Item ry or othe		20a. Method of Disposition ↑☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation / 75 ☐ Other (Special	☐Removal from State	Place of Dispo emetery, crer arden:	sition (Name of natory or other i S Of F	olace) a i + h Nov	Date 9		on-City or To Ville	own, State
Balt	permit. Pages Depertment of Important: If it any injury or once.	1 1	21. Sign ture / Juneral Service to	2 / .)	<u> </u>	onneria 110 So	y Funera 11ers Po		of D	undall 22	k
	Pnysician /Medical Examiner		23a. Pan J. Enter the disease, or come stock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. HYPOXIA Due to (or as a consequence) CHRONIC O	uence of):						Approximate Interval Between Onset and Death
8/60,	certificate be executed adding physicien and see as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conseq c. Due to (or as a conseq d.	uence of):		1				
O. Box 6	death e effer od for u	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Yo 9 ☐ Unknown	23c. If yes, outcome of pregnation of Live birth 2 Feta 4 Pregnant at time of d	I death 3	Ectopic pregna Other (specify			23d.	Date of delive Month	ery Day Year
ds, P.	law requires thet fhe es been signed by fh 2 should be detache	by	Part II. Other significant conditions	contributing to death but not res	ulting in the u	nderlying cause	given in Part I.	23e. Did to			he cause of death?
l Records,	The lay ate hes page 2	Completed						24a. Was autor perfo 1 🗆 Yes		tb. Were auto prior to co death? 1 Yes	opsy findings available impletion of cause of
Vital H	sician: certific recfor,	o Be	25. Was case referred to medical examiner?	Hospital:	5000:		Othor	ath_(Check only o			
on of	ding After fune	-	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. l	4 ☐ Nursing F njury at Nork? ☐ Yes 2 ☐ No	10me 5 Resid			(y)
Division	하셨습니	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		ome, farm, str ý)	eet, factory, offi	СӨ	28f. Location (S City or Tox		umber or Aura	al Route Number,
	Hospitei 24 hours 2 Funeral I	edicai	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exe	hysicien: To the best of my kno miner: On the basis of examina and manner stated.	wledge, death	h occurred at the vestigation, in m	e time, date and place by opinion, death occu	e, and due to the arred at the time,	cause(s) and date and pla	manner as s ce, and due to	tated. o the cause(s)
	To the Hos within 24 h To the Fur completely	Med		F. mazill,	MD		ense number			gned (Month,	Day, Year)
	6		30. Name and address of person who Cathleen F- IM 95				e Baltin				
P.	Sta Regist		31. Date filed (Month, Day, Year)	A. Registrar's Signa	ature		-				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 1 5 1 - State Registra Certificate of Death 2. Date of Death Name (First, Middle, Last) 3. Time of Death Year **Physician** 1558 M November ,2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Samari tan Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, 5. Social Security Number last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1.25 M 2□ F Director Marc Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. important: if item 27 is marked other then "naturel", or items 23a or 28e-f ehov amy Injury or other traumatic event, if a Medical Examinating Institled at once. 1 (es 2 No Completed by Funeral Director 10g. Citizen of What Country? Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: - American Indian White, etc. Black 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) s Name (First, Middle, Last) To Be Name/Relationship (Type, Print) 20a. Method of Disposition Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 23a. Part L. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) certificate has been signed by the a irector, page 2 should be detached in 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 2 □ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 V Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death nerel Director: A filled in by the fu 2 ☐ Accident 6 ☐ Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours after d To the Funerel Direct 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D58570 30. Name and address of person who completed cause of death (Item 23a) (Type, Print), Blvd. Ker, MD 5601 Loch 1 Javen 31. Date filed (Month, Day 32 Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Vaar Evelyn Angell 7:55 PM Nov 2006 Ь 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death JOHNSHOPKING BAYVIEW MEDICAL CENTER BALTIMORE N/A t Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex 8. Date of Birth (Month, Day, Y April 11 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1°1919 Months 287-12-5835 1 ☐ M 2 💢 F OH Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 Yes 2 □ No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21213 USA 3640 Kenvon Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 X No 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White Specify 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sewing Factory Presser 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Alice Martin Charley Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn Jarrells (daughterinlaw) 219 Asbury Road, Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 14 Nov. 4 □ Donation 5 □ Other (Specify) Garrison Forrest Vet. Baltimore, Maryland 2006 of Fineral Service Litenses 22. Name and Address of Facility Stallings Funeral Home, P.A. <u>3111 Mountain Road, Pasadena, MD 21122</u> 23a. Part f. Enter the disease, or complications that dauged the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failuse. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) CRITICAL AORTIC STENDSIS 8 DAYS Due to (or as a consequence of) TYPERCARBIC RESPIRATORY FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): tF FEMALE: thyes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a, Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one Hospital: 1 Inpatient examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Naturat 5 Pending investigation 1 Tes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Physician /Medical Examiner

Department of Important: If any injury or gives.

Physician

/Medical

Examiner

Funeral Olrector

Completed by

Be

Funeral

Director

Pages 1 and 2 should be filed within 72 hours efter death with the Maryland neat of Health and Mental Hygiene.
ant: If item 27 is marked other than "netural", or items 23e or 28e-1 show ury or other traumatic avent, Tra Nuclical Exertian mental candilled at

Baltimore, Maryland 21215-0036

Examiner attending physicien and for use as the burial-transit Physician/Medical ed by the a detached f ğ be Be Completed page 2 s director. ٩ this Certification: After

Hospital or Attanding Physician: The law requires that the death certificate be executed after death.

Diractor: Aft a 24 hours aft Euneral Di letely filled in

Box 68760.

P.O. P

Division of Vital Records,

State Registrar

Medical

DR. GRANT CHOW 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

4 | Homicide

29a. Certifier

MID

Chow

29c. License number RES-000

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) Nov. 6 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940 EASTERN AVENUE BALTIMORE, MD UZZY 32. Abgistrar's Signature

NOV 0 8 2006

within 2 the

			For State Registrer	State of Marylar	nd / Depa <i>Cer</i>	artment of F	lealth and Death		ene 006	35157
			Decedent's Name (First, Middle, Las	t)				2. Date of Death		3. Time of Death
	Physicia /Medic		TIMOTHY BL	ACKSTON				NOVEMBER	Day Yea	
	Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of De		4c. County of De	eath
			JOHNS HOPKINS BAYVI			BALTIM				
	Funeral Director		215-50-5145		72 Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M	in. (Month, Day,)	ear)	Sirthplace (State or Foreign Country) 4RyLand
	land		Usual Residence of Decedent 10a. State 10b. County		ty, Town or Lo					10d. Inside City Limits
	Mary -I sh	to	Md		Balti	more)			1 PYes 2 No
	r 28a	Director	10e. Street and Number	*	1.4	10f. Zip Code		100	. Citizen of What	Country?
	th wit	aiD	1609 W. Faye	The stree	不	215	217		US	A
	me me	Funeral	11. Maritat Status	12. Was Decedent Ever in U Armed Forces?	I.S. 13. V	Was Decedent of H	lispanic Origin? an, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Ar Black, W	merican Indian,
36	or It	by Fu	1 Never Married 2 Married	1 ☑Yes 2 ☐ No	53	Yes 25 No	Specify:			Black
8	hour ture!	ed b	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or Dates: 3/3	,	lent's Usual Occup	ation	14	Sb. Kind of Busine	es/Industry
21215-0036	d within 72 hours after death with the Maryland piene. Ir then "naturel", or Iteme 23a or 28a-f ehow The Medical Examiner must be nutilled at	Completed	(Specify only highest gra	de completed)	(Give	kind of work done DO NOT use retired	during most of v	vorking		
212	TI TO be and	E O	Elementary/Secondary (0-12)	College (1-4or 5+)	JA	initor	_		lepattm	ent of 1) efence
	al Hygi al Hygi I other vent, I	Bec	17. Father's Name (First, Middle, Last)	1 1				lame (First, Middle, Ma	1	
yla	Duid b Ment arked atic	2	O IIII	Lackston			2001	se W	1150n	
Maryland	s 1 and 2 should be filed f Health and Mental Hyg Item 27 is marked othe other traumatic event,		19a. Informant's Name/Relationship (7		19b. Mailin	0	- 1	Rural Route Number, (City or Town, State	, Zip Code)
	1 and 1ealth 1em 27 ther to		growne Barb 20a. Method of Disposition		Place of Disno	sition (Name of	e str		to. (Victor)	or Town State
Baltimore	m O		1 ☑ Buria 2 ☐ Cremation 3 ☐	Domoval from State	cemetery, cren	Park &		11/5006	Relda	n 1 2
틆	교투원급 .		4 Donation 5 Other (Specify 21. Signature of Fundral Service Cen			. Name and Addre	-	/ /	salto.	Chape
Ba	Depa impo eny t		MEARY No	the	16	enn) B	on Aus	an Balla	MI	212
			20a. Part1. Enter the disease, or comp	plications that caused the deal	th. Do not ente	er the mode of dyir	ig, such as card	iac or respiratory arres	1,	Approximate
	Physician		shock or heart favure. List only immediate Cause (Final	HEMORRH	1616	STROKE	_	•		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consec		> I FULLE				2 WEEKS
	Examiner		Sequentially list conditions,	b						
	p. ts	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consec	quence of):					
	cate be executed physicien and the burial-transit	хап	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence)	mence of).					_
8760,	sicien buria	dical E			,					1
687	ficate p physics the	edic		d						
Вох	death certific e attending p id for use as i	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna		·			23d. Date of c	delivery
	0 0 0	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Feta 4 Pregnant at time of c 9 Unknown]Ectopic pregnancy] Other (specify)			Month	Day Year
P.0	that the ded by the	Phys	9 Unknown							
Ś	8 E 9	þ	Part II. Other significant conditions of	antributing to death but not res	sulting in the ur	nderlying cause giv	en in Part I.			to the cause of death? Probably 4 (Pronknown)
0	w requir been si should	eted						_ i res	2 No 3	Probably 4 Púnknown
of Vital Record	e la has	ompieted						24a. Was an autopsy performe	prior t	autopsy findings available o completion of cause of
a	an: The tificete ha tor, page	O	05 W					1 ☐ Yes 2 0	No 1□Y	es 2 No
₹	cer	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 1 Inpatient 2	ER/Outpatien	Oth	0.00	eath (Check only one)	0.7700 (0	
	ding Phys th. After this funeral di	n: To	27. Manner of Death	28a. Date of Injury	28b. Time of	t 3 DOA 28c. Injur Wor	4 Iduising	Home 5 Residen 28d. Describe how		Decity)
<u></u>	Attending r death. ector: After by the fune	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		k? Yes 2 ∐ No			
Division	or Attended of the formal of t	ertification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Specia	ome, farm, stre	eet, factory, office		28f. Location (Stre City or Town,	et and Number or	Rural Route Number,
Ö	ital or irs efte rel Dir led in	Ceri								
.)	To the Hospital or Attenwithin 24 hours efter deat To the Funerel Director: completely filled in by the	edical	(Check only 2 Medical Exam	ysicien: To the best of my knowing: On the basis of examina	owledge, death	occurred at the tir	ne, date and pla pinion, death of	ice, and due to the cau	se(s) and manner and place, and d	as stated. ue to the cause(s)
	thin 2 the I	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens			I. Date signed (Mo	
	1 vit	-								
	^		30. Name and address of person who	completed cause of death (the	m 23a) (Tune		-000	No	VEMBER	6,2006
	4		DR. DEJEDRE FOSTE			•	HIIMOR	E MD 21	224	
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Sign	ajure mart p			-,,	-	
	Registr	ar	NOV 0 8 200	10 the sun L	The State of the S					

			1 - For State Registrar	State of Maryland	/ Department of H Certificate of L			2006	35158
	Physicia	an	1. Decedent's Name (First, Middle, Last)	Bolling		2	2. Date of Death Month	Day Year 4 2006	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give s	,	4b. City, Town, or	Location of Death		4c. County of Deat	
				Saynew Medica		Baltimore		/	VIA
Н	Funeral Director		5. Social Security Number 6. Sex 10	M 25 F	t birthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	B. Date of Birth (Month, Day, Y TULV ()/, /	ear) 9. Birth	hplace (State or Foreign untry) -RVLA-ND
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, 1	Fown or Location				10d. Inside City Limits
	Maryi B-f aho	ţċ	MARYLAND NI	A	BAL	TIMORE	E CIT	7/	1 Yes 2 □ No
	with the	Dire	10e. Street and Number	1-11 / 2.1-	10f. Zip Code	1171	7 109	Citizen of What Co	
	deeth	nerai	11. Marital Status 1	2. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hi	ispanic Origin? (Spec	ify Yes or No-	14. Race - Ame Black, White	rican Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If team 27 is marked other than "natural", or items 23a or 28a-f ahow many injury or other traumatic event, the Modical Examinar must be notified at angle.	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	1 □ Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 🕱 No	Specify:	oarr, 0:0.7	Specify: 13	1 AC V
2-00	72 hou natura	ted	15. Decedent's Educ (Specify only highest grade	ation	16a. Decedent's Usual Occupa (Give kind of work done of	ation	16	6b. Kind of Business/	Industry
21215-0036	within 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done of life. DO NOT use retired	L ANA!	VET	CASTA	1_8
d 2	filed Hygie	Be Co	17. Father's Name (First, Middle, Last)	YKS	MEDEMACH	18. Mother's Name (First, Middle, Ma	viden Sumame)	
ylan	ould be Menta arked atic ev	To B	JEFFERY	Bo	LLING	SHERK	21/	JILL	ES
Maryland	d 2 sh th and th and 27 ls m traum		19a. Informant's Name/Relationship (Type	De, Print)	19b. Mailing Address (Street a	NELL LA	500	ity or Town, State, 2	(D. 21227
ore,	of Heal		20a. Method of Disposition 1. Surial 2 Cremation 3 R	20b. Plac	ce of Disposition (Name of netery, crematory or other place		-	oc. Location - City or	
Baltimore,	t. Pag tment tant: I		4 □ Donation 5 □ Other (Specify)	MT	ZION CEMETO	1	1-06 1	ANSDOWN	E MARYLAND
Bal	Depared Important Important Info		21. Signature of Funeral Service License	William	22. Name and Address	HIH BRO	AVE	BAITO. M	10,21217
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death.	Do not enter the mode of dyin	g, such as cardiac or	respiratory arres	t,	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Asystole					Onset and Death
	Examiner		f.	Cal ciphy lax	•				
	i Xi	iner	Sequentially list conditions, it may be cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequer					
,	te be executed ysicien and se burial-transit	Examiner	that initiated events cresulting in death) Last	Due to (or as a consequent	nce of):	277204			
	e ys	dicai							
Box 68	death certifica e ettending ph id for use as th	n/Med	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome of pregnanc				23d. Date of del	ivery
	at the death by the ette stached for	Physician/M	in the past 12 months? 1 ☐ Yes 2 X No 9 ☐ Unknown	1□Live birth 2 □Fetal de 4□Pregnant at time of deat 9□Unknown				Month	Day Year
P.O.	that the	by Phy	Part II. Other significant conditions con	tributing to death but not resulti	ng in the underlying cause give	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
ords	w requires to been signer should be			paratyroidism			1 🗆 Yes	27 5 (No 3□Pr	obably 4 Unknown
Division of Vital Records,	e la has	Completed	End-Stage Re	nal Disease	2		24a. Was an autopsy performe	prior to d	topsy findings available completion of cause of
tal		a)	25. Was case referred to medical			26. Place of Death	1 Yes 2	No 1 ☐ Yes	2.D. No
ζ	Physician: r this certific ral director,	To B	1 1 185 2 NO		NOutpatient 3 DOA Oth	4 Littliang Hom		ce 6 □Other (Spe	cify)
on c	De je ig	tlon:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	8b. Time of lnjury 28c. Injury Work	yat 28 k? Yes 2 ∐No	3d. Describe how	injury occurred	
ivisi	al or Attending s after death. I Director: After d in 3y the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, factory, office	28	If. Location (Stre City or Town,	et and Number or Ru State)	ural Route Number,
	Hospital or 24 hours after Funeral Discretely filled in 2		29a. Certifier 1X Certifying Phys	sician: To the best of my knowle	edge, death occurred at the line	no date and place as	nd due to the cau	- co/c) and manner as	ctated
	To the Hos within 24 ho To the Fun completely	edical	(Check only 2 Medical Examinations)	ner: On the basis of examination and manner stated.	n and/or investigation, in my o	pinion, death occurred	d at the time, dat	e and place, and due	to the cause(s)
	To the within 2.	Σ	29b. Signature and title of certifier		29c. Licens			d. Date signed (Monta	
,	Λ		30. Name and address of person who co	moleted cause of death (Item 2	Physician UMP #			11-6-2006	
	5		Jesse Kim, Mo, 183	O E. Monument 3	St , Suite 6-100	, Baltimore	, MD 21	287	
	Sta Regist		31. Date filed (Month, Day, Year) NOV 0 8 20	0 E. Monument 3 32. Registrar's Signatur 06	1 Speeds				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** C2104 Buth 10:00 P M Vory Nov 2006 /Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore oilchrist Nursing TOWSON If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sęx 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min. 1 M 2 □ F Yrs. -28-6257 6 Director Szp+-23-1930 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifiled at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Md NIA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 2818 Daktord USA Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 NYes 2 No if Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ۵ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Posta 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bu Dusana 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore
Date 200. Buth Daktord Aue 20b. Place of Disposition (Name of cemetery, crematory or other place) Mattie Md 21215 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 Removal from State Pikesville David Ridge Carnets of Fecility Chatman 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Linesee - Harris 5240 Philsterstown Ad Baltimore Md 21215 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CANCER **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9∐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? δ 1 PYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 performed certificate To the Hospital or Attending Physician: \\
within 24 hours after death.\\
To the Funeral Director: After this certifical filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To DICE 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day Year) 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier no November 2, 2006

State

Registrar

N. Charles St. Balts. and

6401

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

31. Date filed (Month, Day, Year)

NOV 0 8

GAMC

			For	State of Mary	•			ntal Hygier		25160
			State Registrar		Cen	rificate of Dea		Reg. No. 1	2006	35160
	Physicia /Medic		1. Decedent's Name (First, Middle, Las AUGUSTUS	Bul	lock	SR.		No Venker	1	3. Time of Death
	Examin	er	4a Facility Name (If not institution, gire Dal Tinlore H	street and number) Medica	/Center	4b. City Town, or Local Balti	ation of Death More		4c. County of Dear	A
	Funeral Director		21636-641	7. Age (Ir	yrs. last birthday) Yrs.		Jnder 24 Hrs. 8 ours Min.	Date of Birth (Month, Day, Yea		hplace (State or Foreign nuntry) VIC
	anyland show	10	Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Loc	ation				10d. Inside City Limits 12€Yes 2 ☐ No
	the Mi	recto	10e. Street and Number	4 ,	BAI	10f. Zip Code		10g. (Citizen of What Co	
	th with	al DI	3911 Woodrig	ac Rd		2/22	9		2.5.A	,
96	be filed within 72 hours after death with the Maryland tist hygiene id other than "natural", or items 23a or 28e-f show event, the Maritral Examinar must be notified at	y Funeral Director	11. Marital Status 1 Never Married 2 Married	2. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give	lf 1	as Decedent of Hispan Yes, specify Cuban, Mo	nic Origin? (Speci exican, Puerto Ri pecify:	fy Yes or No- can, etc.)	14. Race - Ame Black, Whit	
9	2 hours	ted by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed		16a. Decede	ent's Usual Occupation			Kind of Business	Industry
21215-0036	within 7 ene. than "n	Completed	(Specify only highest grades) Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	ind of work done during O NOT use retired) STee 1D	orker		AEKing	STeel
and 2	be filed ntal Hygia od other event, I	Be	17. Father's Name (First, Middle, Last)		<u> </u>			First, Middle, Maid	en Surname)	
Maryland	2 should be and Mental is marked o	2	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailing	Address (Street and N	Seff C Number or Rural I	Route Number, City		Zip Code)
_	alth altr		Shieley Bulloc	K	391	1 Words	idgok	the same of the sa	e.mD	21229
more	Pages 1 and nent of Heam ant: If item		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State		atory or other place)	Da		Location · City or	
Baltimore,	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Licen		- 22. - 3	Name and Address of	recally near	Hone	ATT. MOR	2/2/2
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the	death. Do not ente	r the mode of dying, su	ich as cardiac or		n-11.000	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Metagti	ate lun	g cancer				Onset and Death
ı	Examiner		Sequentially list conditions,	b						
	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	onsaquence of).					
8760, <	ate be executed hysician end the burial-transit		that initiated events resulting in death) Last	Due to (or as a co	ensequence of):					
687	# \$ # #	edical		d.	70.0					
P.O. Box	that the death certific ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3 I	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
	8 E 9	þ	Part II. Other significant conditions co	entributing to death but n	ot resulting in the un	derlying cause given in	Part I.	1		othe cause of death?
Division of Vital Records,	he law e has b aga 2 si	ompleted						24a. Was an autopsy performed	prior to death?	itopsy findings available completion of cause of
/ital	ysician: T is certificat director, pa	Bec	25. Was case referred to medical examiner?			1 -	Place of Death (10 100	
J o	Phys raldi	5	1 Yes 2 No 27. Manner of Death	Hospital: Inpatient	2 ☐ ER/Outpatient 28b. Time of			e 5 ☐ Residence		cify)
<u>o</u>	ding h. Afta fune	atlon	1 Natural 5 Pending 2 Accident investigation		ear) Injury	28c. Injury at Work? M 1 Yes			,,	
Divis	at or Attences after death	ertification;	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (S	- At home, farm, stre Specify)	et, factory, office	28	f. Location (Street City or Town, Sta		ural Route Number,
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director; completely filled in by the	edical C	29a. Certifier Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of m niner: On the basis of exa and manner stated	amination and/or invi	occurred at the time, destigation, in my opinion	ate and place, an n, death occurred	d due to the cause I at the time, date a	(s) and manner as and place, and due	s stated. to the cause(s)
	To the I within 2 To the I complet	Me	29b. Signature and title of certifier	W F		29c. License nur			Date signed (Monti	
	photosym-		30. Name and address of person who of Jeffrey Liu		ı (Item 23a) (Type, F	Print)	V. Bros	ne St 1	Solt wa	, 2006 re, MD 21201
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's		Saels?	. 41 66	10 0 1	-61/170	-, 100124
			MUYUOZ	UUUI Jan	J. A					

DHMH 17 Rev 1/2001

ORIGINAL

		•	for State Registrar	State of Marylan			t of Heal			ene g. No2 0 0 (5 35161
ì	Physici /Medio Examin	al	1. Decedent's Name (First, Middle, Las LAUVA BILVE 4a. Facility Name (If not institution, give			4b. City,	Town, or Loca	tion of Death	2. Date of Death Month Novembe	Day Yea	6 1114 PM
	Funeral Director		5. Social Security Number 6. S	Jund Midical Dx 2XF 7. Age (In yrs. 43	Center last birthday) Yrs.	If Under Months	1	MOV L. nder 24 Hrs. urs Min.	8. Date of Birth	Y1 963 Wa	Sirthplace (State or Foreign Country) Ishington DC
	Maryland a-f show	ctor	10a. State 10b. County MD Ann An		y, Town or Lo		e				10d. Inside City Limits 1 ☐ Yes 2 XNo
	h with the	al Dire	7876 E Tall Pir	nes Ct		10f. Zip	Code 2	1061	10	g. Citizen of What USA	Country?
920	d within 72 hours after death with the Maryland Jiene. r than "natural", or Itema 23e or 28e-f show the Macical Examinar must be notified at	by Funeral Director	11. Marital Status 1 Mever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Vas Deced Yes, spec	35 35	c Origin? (Spaxican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - A Black, W Specify:	merican Indian, hite, etc. White
21215-0036	77 75 6 88	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12	ucation de completed) College (1-4or 5+)	(Give	lent's Usua kind of wor OO NOT us Shie	I Occupation of done during se retired)	most of work	ing	6b. Kind of Busine Home	
land;	id be filed lental Hygie ked other ic event, the	To Be C	17. Father's Name (First, Middle, Last) Sanford Bienen						e (First, Middle, M imbinne:	aiden Sumame)	
, Maryland	aith and Mari		19a. Informant's Name/Relationship (7 Sanford Bienen/	ype, Print) father							gs W. VA
Baltimore,	permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg mportant: if Item 27 is marked othe my hijury or other traumatic event, 2028.		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State Che		ke C	_{ther place)} remato	ory 1	L/8/06	Oc. Location - City Beltsv	or Town, State ille, MD
Bal	permit. Departm Importa any inju		21. Signature of Funeral Service Licen	Ritter Mal	44387	17 G		Pastui			ore MD 212&
≥,092	Physician and hysician and physician and physician the purial-transit	cai Examiner	23a. Part1. Ehter the disease, or companies shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Gustwith Due to (or as a consequence course) Due to (or as a consequence course) Due to (or as a consequence course) Due to (or as a consequence course)	uence of): uence of):	er the mode	e of dying, suc	th as cardiac of	or respiratory arre	st,	Approximate Interval Between Onset and Death 3 days
P.O. Box 68	death certific e ettending pl d for use as t	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ②No 9 □ Unknown	23c. If yes, outcome of pregnation 1 Live birth 2 Feta 4 Pregnant at time of degree Unknown	ıl death 3 □	Ectopic pro				23d. Date of Month	delivery Day Year
	uires that signed by Id be deta	ρ	Part II. Other significant conditions of	ontributing to death but not res	ulting in the ur	iderlying ca	ause given in F	Part I.	23e. Did toba	\/	o to the cause of death? Probably 4 □Unknown
al Recor	: The law requires that the cete hes been signed by th page 2 should be detache	Completed							24a. Was an autopsy perform 1 Yes 2	ept? prior t death	autopsy findings available to completion of cause of ? es 2 \(\square\) No
Division of Vital Records,	Attending Physician: The reath. c death. sctor: After this certificete by the funeral director, pag	tlon; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatient 2 2 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury			☐ Nursing Ho	me 5 Residen 28d. Describe how	nce 6 □Other (S	pecify)
Divis	al or Attendi s after death. I Director: A d in by the fu	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, stre	et, factory	, office		28f. Location (Stre City or Town,		Rural Route Number,
	To the Hospital or Attenwithin 24 hours after deation to the Funeral Director: completely filled in by the	edical (29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my knowing. On the basis of examination and manner stated.	owledge, death	occurred a restigation,	at the time, da in my opinion	te and place, death occurr	and due to the cas	use(s) and manner te and place, and c	as stated. tue to the cause(s)
)	To the within 2 To the comple	W	29b. Signature and title of certifier	- m1	7	290	License num			d. Date signed (Mo	
	1,3		30. Name and address of person who aleann Silhan,	completed cause of death (Item	n 23a) (Type, 1 South	Print)	ene S		711	eto mi	× 3, 2006
	Sta Registi		31. Date filed (Month, Day, Year)	32 Registrar's Signa	tura &	and i					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year 11:50 P^M Peter Allen Bulkley November 3 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 9808 Davidge Drive Columbia Howard If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 XI M 2 □ F 085-54-6110 Director 37 Nov 14, 1968 New York Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits Director 1 TYes 2 XNo MD Howard Columbia 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or 9808 Davidge Drive 21044 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 2 X No 1 ☐ Yes 2X No Specify. Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) a H Executive Computer Software permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) å Jonathan Andrew Bulklev ပ Eliane Froment 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fabienne I. Bulkley /spouse 9808 Davidge Drive, Columbia, Maryland 21044 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) W. Arundel Crematory Nov 7, 06 Odenton, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Donaldson Funeral Home, P.A. DeWitte M00773 313 Talbott Ave. Laurel, Maryland 20707-4389 23a. Part1. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final disease or condition resulting in death) Physician Metastatic Pancreatic Cancer year /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner faw requires that the death certificate be executed burial-tra Due to (or as a consequence of): attending physician Physician/Medical the IF FEMALE: nse s 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy jo in the past 12 months? Month 4□Pregnant at time of death Dav Year 5 ☐ Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an autonsy perform certificate 1□ Yes 2 X No Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 X No Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation 1 X Natural 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0051860 November 6, 2006 40 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

Jonathan Fish,

31. Date filed (Month, Day, Year)

M.D

32. Redistrar's Signature

Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

10700 Charter Drive, #200, Columbia, MD 21044

			1 - For State Ragistrar	State of Ma	rylar	nd / Depa <i>Cei</i>	artme <i>rtifica</i>	ent of He ate of D	ealth a Death	and M		giene Reg. No		6	3516	3
	Physici.	an	1. Decedent's Name (First, Middle, Last Amanda Jane B) Jyrd							2. Date of Dea Month	Da		Year	3. Time of De	
	/Medic	al	4a. Facility Name (If not institution, give				4h Ci	ty, Town, or	ocation (Novembe	7	, 200 County o		2:30 A	
	Examin	ei	11002 Bowerman Ro				40. 0.	White						ltim	ore	
	Funeral Director		217 34 1031	7	(In yrs.	last birthday) Yrs.	If Und Month	der 1 Year s Days	If Under Hours	Min.	8. Date of Birt (Month, Day March 2	Year	938		place (State or Fo ntry) YLand	oreign
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							1	0d. Inside City L	imits
	Mary 9-f sh	tor	Maryland Baltimor	.e			Wh	te Ma	rsh						1 Tes 2	() No
	or 28	Dire	10e. Street and Number				10f.	Zip Code				-	tizen of W		ntry?	
	eath w	erai	11002 Bowerman Ro	12. Was Decedent E	vor in L	6 12 1	Mac Do		21162		aifu Vas ar Na		U.S.		an Indian,	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "neturel, or Items 23a or 28e-f show environty or other treumette event, I're Mudical Examiliar must be nutified at once.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Moivorced	Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:		1	fYes, s	2 X No	Specify:	n, Puerto I	cify Yes or No- Rican, etc.)			, White,		
20	72 hou	eted	15. Decedent's Edu (Specify only highest grad	ication		(Give	kind of	sual Occupat	ion	t of workin	20	16b. K	(ind of Bus			
21215-0036	within ane.	mple	Elementary/Secondary (0-12)	College (1-4or 5	+)	Sale	DO NO1	use retired)	,,,,,g 1.1.03	01 1107/07	,g	Can	munic	rati	an	
	Hygie other	Be Co	17. Father's Name (First, Middle, Last)			June	Spe		18. Mothe	er's Name	(First, Middle,					
/lan	ould be Menta arked	To B	George S. Bower	man, Sr.					Minn	rie	Trout					
Maryland	12 sho n and l		19a. Informant's Name/Relationship (7) Sharon Byrd (_(рв. Print) daughter)							Route Numbe			tate, Zip 1229	Code)	
	is 1 and 2 of Health ai Item 27 is		20a. Method of Disposition	umyntel)	20b. F	Place of Dispo	sition (A	lame of	1		ate		ocation - C		wn, State	
Ē	Pages nent of nt: If I		1 ☐ Burial 2 🛣 Cremation 3 ☐ F `4 ☐ Donation 5 ☐ Other (Specify)			gemetery, crem Yview (11/6	/2006				laryland	ł
Baltimore,	permit. Departrimporte		21. Signature of Faneral Service Licens	00	1				of Facilit	Schi	munek F ltimore				5	
			23a. Part1. Enter the disease, or composhock, or heart failure. List only o	ications that caused ne cause on each lin	the deat										Approximate Interval Betwee	
j.	Physician		Immediate Cause (Final disease or condition resulting in death)) rel	ass	terte	le	Ly C	an	en				Z	Onset and Dear	1
	/Medical Examiner		resulting in death)	Due to (or as a	consec	juence of):		J								
	7 -	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	conseq	juence of):										
	ficate be executed physician and s the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C												
68760,	be ex sician burial	aiE	A sound of the sou	Due to (or as a	conseq	luence or):										
_	ifficate g phys	edicai		d												
Вох	The law requires that the death certif Ie has been signed by the attending lage 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of			Ectopic	pregnancy					23d. Date			
P.O.	he dea the al	ysici	1 Yes 2 No 9 Unknown	4☐Pregnant at 9☐Unknown	ime of c	leath 5□	Other (specify)					Mont	11	Day Year	
	that II	by Ph	Part II. Other significant conditions co	ntributing to death bu	t not res	ulting in the ur	nderlying	cause giver	n in Part I.		23e. Did to	bacco	use contrib	ute to th	e cause of death	h?
Division of Vital Records,	w requires been sign should be										102 Y	es 2	□No 3	Prob	abiy 4 □Unkr	nown
eco	e law requ has been je 2 shoul	Completed									24a. Was a	SV	24b. We	ere autor	osy findings avai	lable e of
冒田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田	icien: The certificate h rector, page										perfor 1 Ves	med? 2₩ No	de	ath?] Yes		
Ž	/sicier s certif	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital:	nt 2	ER/Outpatien	t 3 🗆 I	Other			(Check only or		€ □Othor	/Cnnnih		
l of	Attending Physicien: r death. sctor: After this certifice by the funeral director, p	-	27. Manner of Death 1. Natural 5 □ Pending	28a. Date of Injur (Month, Day		28b. Time of Injury		28c. Injury a			8d. Describe h				7	
<u>Sio</u>	tendingeath.	catio	2 Accident investigation 3 Suicide 6 Could not be				М	1 🗆 Ye	9s 2 🗆 !							
$\overline{\underline{S}}$	afor At after Direct J Direct J Direct	Certification:	4 Homicide determined	28e. Place of Inju building, etc	ry - At h (Specif	ome, farm, stre y)	et, fact	ory, office		2	81. Location (S City or Tow	treet ar n, State	nd Number a)	or Rura.	l Route Number,	
	To the Hospitel or Attending Physicien: The within 24 burs after death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page	Medical (29a. Certifier (Check only one) Certifying Phy Certifying Ph	sician: To the best on nar: On the basis of and manner stat	examina	wledge, death	occurre	d at the time on, in my opi	, date an	d place, a th occurre	nd due to the o	ause(s late and) and manr d place, an	ner as st d due to	ated. the cause(s)	
	To the within 2 To the complet	Ř	29b. Signature and title of certifier				2	9c. License	number		2	9d. Da	te signed (Month, L	Day, Year)	
	5		m. Timel	2				0147	14		1	1/3	101	5		
4	1			Hell J.	48	VMC	49	40 3	RIT	RKN	Kue,	BL	INUL	s / /v	42122	4
•	Sta Registr	-	31. Date filed (Month, Day, Year) NOV 0 8 2006	. Registra	s Sign	ture Spe	and I									

		For	State of Maryland	/ Depa	rtment of H	lealth and	Mental Hyg	giene	
		1 - State Registrar			tificate of l			Reg. No. 2006	35164
Physici	an	1. Decedent's Name (First, Middle, Last)		-			2. Date of Dea Month	Dav Yea	3. Time of Death
/Medi	al		Busick				Novembe	r 4, 2006	8:10 P M
Examir	er	4a. Facility Name (If not institution, give stre 521 Carrollwood			•	Location of Death Timore	l.	4c. County of D	eath timore
Funeral		5. Social Security Number 6. Sex		t birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt		
Director		216-18-4194 1XM	2□F 81	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day Jan. 16	, 1925 M	Birthplace (State or Foreign Country) WYLANd
pur *		Usual Residence of Decedent 10a. State 10b. County	10c. City. 1	Town or Loc	eation				10d. Inside City Limits
Manyla f sho	Į.	Maryland Baltimore			Baltimo	r.o.			1 ☐ Yes 2 No
r 28a-	rect	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
th with 23a o	Funeral Director	521 Carrollwood Roo	ıd			21220		u.s.	Α.
tems	uner		Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - A Black, W	mencan Indian, /hite, etc.
s afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 X Yes 2 □ No If Yes, Give Year or Dates: WW II	1	☐Yes 2X No	Specify:		Specify:	White
be filed within 72 hours after deeth with the Marylan lat Hygiene. Id other than "natural", or Items 23a or 28a-f show event, it a Medical Examinatory and the mullibed at	ted t	15. Decedent's Educat	ion	16a. Deced	ent's Usual Occup	ation		16b. Kind of Busine	ss/Industry
thin 7:	Completed	(Specify only highest grade c	ompleted) College (1-4or 5+)		kind of work done of NOT use retired		king	Internal	Revenue
led wi ygien yein her th	Con		2	Coll	Lection A			Service	
ibe fil ntal H ed otl	Be	17. Father's Name (First, Middle, Last) Robert Busick				18. Mother's Nan	ne (First, Middle, Smith	Maiden Sumame)	
In year to 2 12 13 13 13 13 13 13 13 13 13 13 13 13 13	은	19a, Informant's Name/Relationship (Type	Print)	19b. Mailin	g Address (Street			ar, City or Town, Stat	e, Zip Code)
nd 2 : alth ar 27 le er treu		Cheryl A. Jones	(daughter)					n, Maryla	
Pages 1 and 2 ment of Health a ent: If item 27 is ury or other tre		20a. Method of Disposition 1 Burial 2 Cremation 3 Rem	cem	netery, crem	sition (Name of natory or other place		Date	20c. Location - City	
Pagiment tent: I		`4 □ Donation 5 □ Other (Specify)	Gara						, Maryland
permit. Pages 1 and 2 should Department of Health and Men Importent: If tiem 27 1e marke any injury or other treumatic.		21. Signature of Pyneral Service Licensee						Funeral H , MD 2123	
		23a, Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the death.					-	Approximate
Physician	Н	Immediate Cause (Final							Interval Between Onset and Death
/Medical		disease or condition resulting in death)	Due to (or as a consequent of the consequent of	nce of):	MULLI				= years
Examiner	L	Sequentially list conditions, b.	cigan	J'M	no King				
led sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	nce of):	0				4
be executed sician and burial-transit	Exar	that initiated events c. resulting in death) Last	Due to (or as a consequen	nce of):					
OI VICAL INSCULAS, T.O. BOX 60100, Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	cail	d							
us, r.C. box ob railings that the death certificate is signed by the attending physide be detached for use as the district that it is not a signed to the signed by the signed for use as the district that is not the signed to t		IF FEMALE:		-					
ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	. If yes, outcome of pregnand 1 Live birth 2 Fetal d	eath 3	Ectopic pregnancy	,		23d. Date of Month	delivery Day Year
the de	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of dea 9☐Unknown	tn 5L	Other (specify)				
i that i	by Ph	Part II. Other significant conditions contri	buting to death but not resulti	ing in the ur	nderlying cause giv	en in Part I.	23e. Did to	obacco use contribut	e to the cause of death?
w requires been significations and the second period of the second period of the second period of the second of th	ed b	PANKINSON.					124	es 2□No 3□	Probably 4 Unknown
din Ol VII. Ol VII. Old INFO COLO Using Physician: The law requir. In. After this certificate has been stuneral director, page 2 should	Completed	Vordunutart	yon				24a. Was		autopsy findings available to completion of cause of
The The page	Com	Pritarial 141/	entension				perfo 1 Yes	rmed? death	1?
VILAI ician: T certificat rector, p	Be	examiner?	nital:		Oth	26. Place of Dea	The state of the s		
	. To	TE THE ZURING	1 Inpatient 2 LE	8b. Time of		4 ☐ Nursing H		dence 6 Other (S	Specify)
Vitending death.	ation	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		k? Yes 2 □ No	-		
l or Attendated by the Director:	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	ie, farm, str	eet, factory, office		28f. Location (5 City or Tox	Street and Number of vn, State)	Rural Route Number,
To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funerel		29a, Certifier 1 Certifying Physic	ions To the best of my knowled	odoo daash		- data and place	and due to the		
24 hc 24 hc e Fun	edicai	(Check only one)	ian: To the best of my knowler: On the basis of examination and manner stated.	n and/or inv	restigation, in my o	pinion, death occu	rred at the time,	date and place, and	r as stated. due to the cause(s)
To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signed (M	onth, Day, Year)
		> A hope	2 MD		219	1811		1/- 6	- 06
th		30. Name and address of person with com	pleted cause of death (Item 2 // D 8 4/1 S 32. Registrar's Signatur	23a) (Type,	Print)				6.46
<i>y</i> v	ate	ADDLED LDPEZ 31. Date filed (Month, Day, Year)	32. Registrar's Signatur	BE	LCONA	LANG "	10WSD	NIND	2/204,
Regist		NOV 0 8 200	6 Regues 1	J. 19					

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year Lawrence George Buell, Jr. November 4. 10:18 A M 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 8909 Whitecliff Lane Parkville Baltimore. If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 9. Birthings (Country) Sept. 28,1934 Maryland 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F 72 220-30-7297 Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than *natural', or itams 23a or 28e-f show any njury or other treumatic event. If a M-dical Examiner must be pullified at once. 10d. Inside City Limits 10a State 10h Counts 10c. City, Town or Location Maryland Baltimore Parkville. 1 Tes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8909 Whitecliff Lane 21234 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S.
Armed Forces?

1 (XYes 2 | No.
If Yes, Give Korean
Year or Dates: Conflict 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specity: White 3 ☐ Widowed 4 Noivorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Baltimore Gas and Elementary/Secondary (0-12) College (1-4or 5+) Electric Co. Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lawrence George Buell. Sr. Mary Ann Byrne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laurie Buell Griffie (daughter) 27 Krenkel Court, Flemington, NJ 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem'l [11/09/2006 | Timonium, Maryland * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 23a. Peri 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Leath Immediate Cause (Final disease or condition resulting in death) cardial **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed use as the burial-transi that initiated events been signed by the attending physician and should be detached for use as the burial-trai resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ②No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospitel or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 ☐ Nursing Home 5 PResidence 6 ☐ Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 4 hours after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier. 29c. License number 29d. Date signed (Month, Day, Year) 21204 30. Name and address of person who computed cause of death (Item 23a) (Type, Print) CARL15 6701 N. Charles St., Suite 4202, Towson, MD Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 0 8 2006 Registrar

State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Month Year 3.05 A M WILLIAM yovember BROWN 05 2006 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Randallstown Northwest Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1**X**M 2□ F 88 Director 217-09-7482 MD Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Iteme 23a or 28a-f show other traumatic event, the Mactical Examinar must be notified at 1 TyYes 2 No Director NA Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of Whal Country? 21230 U.S.A. 2206 Patapsco Ave 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. a filed within 72 hours after dail Hygiene.

Other than "natural", or Item Black, White, etc. 1 ☐ Yes 2 █️No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Steamship Trade Long Shoreman 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ss 1 and 2 should be fill of Health and Mental H Sarah Robinson William Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 21201 112 B Fremont Ave, Baltimore, Md Hazel Brown-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 nent of P 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion 11/10/06 Baltimore, Md 21. Signature of Funeral Service Licens 22. Name and Address of Facility March F/H West arch a 21215 4300 Wabash Ave, Baltimore, 23a. Part 1. Enlier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** COMESTIVE HEART FAILURE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physiclan and s the burial-transit Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. Physician/Medical use as the ed by the attending detached for use as IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death | Check only one examiner' Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1. Certifying Physicism To the best of my knowledge, death becumed at the time, date and place, and due to the cause(s) and mainter as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Cortifie Medicai (Check only 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) Mella m.D in dea 041410 November 05, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOSINGER P MEHTH MORTH WEST CENTER RAYOALLS TOWN MO 21133 2. Registrar's Signature 31. Date filed (Month, Day, Year) NOV 0 8 2006 State Registrar

or other traumatic event, the Madical Examiner must be notified at or iteme 23a permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or itemeny injury or other traumatic event, the Macinal Examination. Baltimore, Maryland 21215-0036

Physician

Funeral

Director

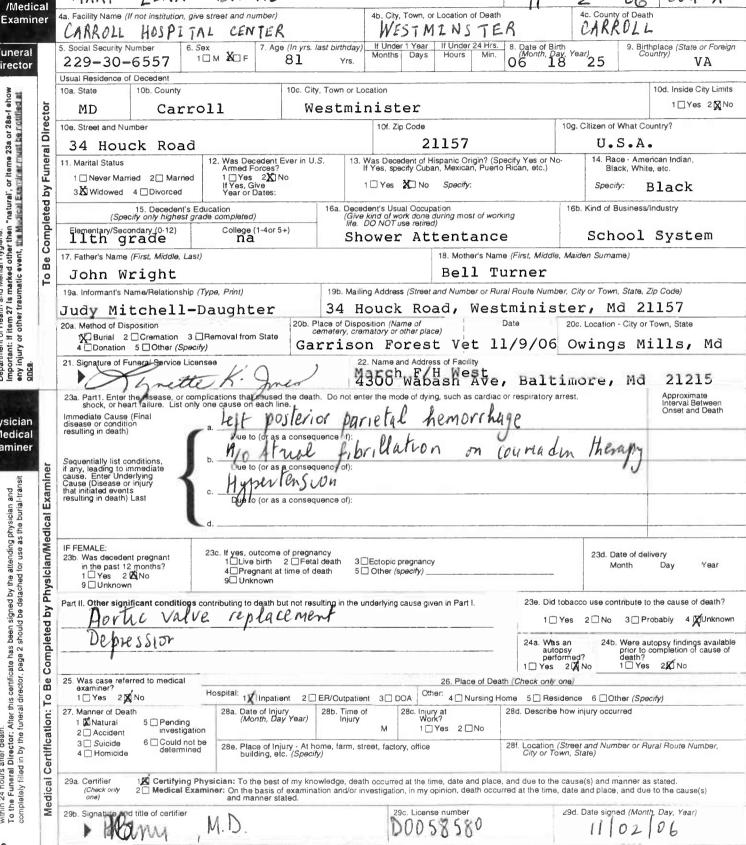
or 28a-f ehow

Physician /Medical **Examiner**

signed by the attending physician and d be detached for use as the burial-transit peen : this certificate has

certificate be executed Division death.

of Vital Records, P.O. Box 68760. To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: completely filled in by the



State Registrar

LN B21 BOWIE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3233

NOV 0 8 2006

Kanu . 31. Date filed (Month, Day, Year) SUPERIOR

32. Registrar's Signature

			1 - For Registrar	State of M	arylar				ealth a	and M		gienę Reg. Né	2 H H K	, ,	351	68
	Physici	an	1. Decedent's Name (First, Middle, Las					-			2. Date of De.	ath			3. Time of	
	/Medic	al	Grover 4a. Facility Name (If not institution, give	Brewer			4b. City	Town, or	Location o	of Death	NOv 2,	-	County of De	ath	8:15	AIMM
	EXAMINI	ei	Southern Mary		ital		,	Clin					rince		rge's	
	Funeral Director		5. Social Security Number 6. Se 425 34 8072	7. Ag	e (In yrs. 82	last birthday) Yrs.	If Under Months	1 Year Days	If Under a	24 Hrs. Min.	8. Date of Birt (Month, Da Aug 26	th y, Year)		Country	ce (State o	_
	D.		Usual Residence of Decedent	AA							Aug 20	, 19	24 11	1991	1221h	hт
	anylar show	ž	10a. State 10b. County		10c. Cit	ty, Town or Lo								10d	l. Inside Ci 1 ☐ Yes	•
	the M	Director	Maryland Prince Ge	eorges		CI	intor		-			10a Cit	tizen of What	Country		-X-X ***
	th with		9211 Stewart	Lane				2073	5			_	ted St			
	teme	Funerai	11. Marital Status	12. Was Decedent Amed Forces?		I.S. 13.	Was Dece f Yes, spe	dent of Hi cify Cuba	spanic Orig	gin? (Spe , Puerto l	cify Yes or No- Rican, etc.)	-	14. Race - Ar Black, Wi			
39	within 72 hours after deeth with the Maryland ene. Then "natural", or Iteme 23a or 28e-f show he Mudical Examilian roual be mulified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 ☐ If Yes, Give Year or Dates:	No		1 ☐ Yes	2 / X No	Specify:				Specify:	Whit	te	
2-0	72 hou	Completed	15. Decedent's Ed			16a. Deced	dent's Usu	al Occupa	ation Juring most	of working	na	16b. K	and of Busines	s/indus	stry	
121	within ane. then	mpi	Elementary/Secondary (0-12)	College (1-4or	5+)	life. I	chool	se retired,)		.9	C	harles	Cox	ıntv	Ed
d 2	Hygie other	Be Co	17. Father's Name (First, Middle, Last)	<u> </u>				100		r's Name	(First, Middle,				IIICy -	Щ.
ylar	Menta Menta mrked artc ev	To B	Grady 1	Brewer						Abbi	e Arnol	Ld				
Baltimore, Maryland 21215-0036	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Marylan Department of Heelih and Mental Hygiene. Importment of Heelih and Mental Hygiene. Instructi, or theme 23a or 28a-f show any injury or other treumatic event, the Mudical Examinar mast be nutitied at once.	y 7	19a. Informant's Name/Relationship (7)	ype, Print)		1 555					Route Numbe				ode)	
<u>ē</u>	s 1 end f Heelt Item 2 other		Dan Brewer (Son) 20a. Method of Disposition		20b. F	2502 Place of Dispo cemetery, cren	Sena sition (Nai	tor ne of	Ave	Fore	stville		D 2074 ocation - City		n, State	
<u><u>E</u></u>	Page nent o ant: If ury or		1 Description 2 □ Cremation 3 □ Cremation 3 □ Cremation 3 □ Other (Specify)	Removal from State)		lary1an						Ch	eltenha	am.	MD	
3alt	permit. Departr Importu		21. Signature of Funeral Service Licens			22	. Name ar	nd Addres	s of Facility	Lee	Funera	1 H	ome, In	1c 6	633 (01d
	40344		23a. Part1. Enter the disease, or comp	lications that caused	the deat					-	ad, Cli		n, MD	207	735 opproximate	Δ
	Physician		shock, or heart failure. List only of Immediate Cause (Final	ne cause on each li	ne.	scherot		_						In	nterval Bety Inset and D	ween
	/Medical Examiner		disease or condition resulting in death)	aDue to (or as			10		all o	ma	lan D	120	lise	+-	120	5
	Examiner	-	Sequentially list conditions, if any, leading to immediate	b. Due to (or as		mon; c								-	3 ~	enly
Γ	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	200 10 (0) 43	a conseq	derice on.										
Ö,	ate be executed hysicien and the burial-transit	Еха	resulting in death) Last	Due to (or as	a conseq	uence of):										
8760,	cate b physic the b	dicai	•	d												
ŏ	n certifi anding use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome									23d. Date of d	elivery		
Division of Vital Records, P.O. Box	The law requires that the death certificate be executed ite has been signed by the ettending physicien and bage 2 should be detached for use as the burial-transit	by Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown			Ectopic pr Other (sp						Month	Da	ay Y	Year
<u>ч</u>	that the	y Ph	Part II. Other significant conditions co	ntributing to death b	ut not res	ulting in the ur	nderlying c	ause give	n in Part I.		23e. Did to	bacco u	use contribute	to the o	cause of d	eath?
rds	w requires to been signer should be										1 🗆 Y	es 2	□No 3□I	Probabl	ly 4.⊘du	Jnknown
ဗ္ဗ	law re has be e 2 sh	Completed									24a. Was autop	sy		compl	y findings a letion of ca	available ause of
<u>8</u>	n: The ficete or, pag	e Co	25. Was case referred to medical			-	_					258 No	death?		Ø No	
\leq	ysicia is cert directo	To Be	examiner?	Hospital: 1 ⊠ Inpatie	ent 2 🗍	ER/Outpatien	t 3□ DC	Othe			Check only one 5 Resid		6 □Other /Sc	ecifu)		
0	Attending Physician: r death. sctor: After this certifice by the funeral director, i		27. Manner of Death 11 Salatural 5 ☐ Pending	28a. Date of Inju (Month, Da		28b. Time of Injury		8c. Injury Work	at ?		8d. Describe h			00.147		
<u>s</u>	death.	icati	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Inj	uny - At h	ome farm etre	M factor		es 2□N		8f. Location (S	troot an	d Alumbar or i	Pura LD	Parista Africa	
<u>≥</u>	elor A s efter al Director	Certification:	4 Homicide determined	building, et	c. (Specif	y)	ser, ractory	, once			City or Tow	m, State)	nurai m	oute Numi	oer,
	To the Hospitel or Attending Physician: The law within 24 hours effer death. Without Foundard Director; After this certificate has completely filled in by the funeral director, page 2	edical (29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best iner: On the basis of and manner sta	examina	owledge, death	occurred restigation	at the tim , in my op	e, date and inion, deat	place, a	nd due to the d d at the time, d	ause(s)	and manner a	as state	e cause(s))
	To the within To the comple	Me	29b. Signature and title of certifier	and mainter out			290	. License		4.5			te signed (Mor			
)	1		moin					D	453	65			11-02	- 2	2006	1
1	XI		30. Name and address of person who co	ompleted cause of d	eath (Iten	n 23a) (Type, I	Print)	Ril	#11	1. f.	Jh	29 h	ta M	0	2071	14
	Sta	te	31. Date filed (Month, Day, Year)	32. Regist	ar's Signa	iture 19	ha	Al B	(2	/			.,,			/
	Registr	ar	NOV 0	S ZUUP >	Callana	1 15	Service Contract of the Contra	33								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month November 6, 2006 **Physician** 10: 27A M Van Buskirk /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's 9405 Silver Fox Turn Clinton If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 79 Yrs. 152 14 2356 1927 July 2, New Jersey Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☐ No Prince George's Clinton Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 20735 9405 Silver Fox Turn Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes XX No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√XNo Specify: White Completed by XXWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Communications Technician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pauline Briggs Edgar William Buskirk 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type. Print) 3116 Burgess Road, Chesapeake Beach, MD20732 Linda Miller (Executrix) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 XX urial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery Nov 10,2006 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature Alexandria Ferry Road, Clinton, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical **Examiner** Esquentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed the burial-trar and resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed? Yes 211 No 2□No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Qther (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident neral Director: , filled in by the f 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide hours after within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 445 Defense Highway, Annapolis, Md. Michael LaPinta, MD 32. Registrar's Signature 08 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydier® 0.0 C

			1 - For Amend item#17,	perFh,G861,1	aryland / Dep $11/8/06~{ m TT}$ $C\epsilon$	ertificate of	Death	Mental Hyg	leg. No.	35170
	Physici	an	1. Decedent's Name (First, Middle, Las	1)				2. Date of Dea Month	th Day Year	3. Time of Death
	/Media		Dolores J. Bath					Nov. 3.		8:45 A M
	Examir	er	4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of Deat	th	4c. County of Deat	h
			Genesis Eldercare 5. Social Security Number 6. Se			Brooklyr	Park		Anne Arur	
	Funeral Director				e (In yrs. last birthday 65 Yrs.	Months Days			, 1941 Mary	hplace (State or Foreign untry) 7 1 and
	land wo		10a. State 10b. County		10c. City, Town or L	.ocation				10d. Inside City Limits
	Mary	ţŏ	MD Anne Aru	ndo1	Proplet-	D1				1 ☐ Yes 2√☐ No
	r 28a	Director	10e. Street and Number	nder	Brooklyn	10f. Zip Code	· · · · · · · · · · · · · · · · · · ·	1	log. Citizen of What Co	untry?
	h witi	O E	518 Taney Ave.			21225			USA	
	deat	Funerai	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of H	lispanic Origin? (S	specify Yes or No-	14. Race - Ame	ncan Indian,
21215-0036	d within 72 hours after death with the Maryland Jiene. r than "natural", or items 23a or 28s-f ehow The Medical Examinar must be rodified at	Ď	1 ☐ Never Married 2☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	No	1 ☐ Yes 2 ☒ No	Specify:	ite	Specify:	aite
5-0	72 hc natur	ete	15. Decedent's Edi (Specify only highest grad		16a. Dece	edent's Usual Occup s kind of work done	pation		16b. Kind of Business/	
7	within ene. then	Completed	Elementary/Secondary (0-12)	College (1-4or	life	DO NOT use retire	d)	iking		
	ygier th		12		Home	emaker			Home	
<u>n</u>	be filed stal Hyg ad othe avant,	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nar	me (First, Middle, i	Maiden Sumame)	
3	should nd Mer marks umatic	2	Milton Ratman				Marie De			
Maryland	12 st h and 7 ie n treun		19a. Informant's Name/Relationship (T)						, City or Town, State, 2	ip Code)
	1 and Health		David H. Bathgate 20a. Method of Disposition	- Husband	1 518 20b. Place of Disp		e. Brook		MD 21225	F 0
Baltimore,	nit. Pages 1 and 2 should be filed artment of Health and Mental Hyg ortant: If Item 27 Ie markad othe Injury or other traumatic avent, 9.		1 ☐ Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State	cemetery, cre	matory or other plac	1		20c. Location - City or	
量	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Licens		Metro Cre	EMatory 2. Name and Addre	NOV .	. 4, 06 E	Baltimore, 1	MD
ã	Depa impo any i		1/m 11	lach !	Parl 9	Cremation	Society	of Maryl	and, Inc. ore, MD 212	20
			23a. Part. Enter the disease, or comp	lications that caused	the death. Do not en	iter the mode of dyir	ng, such as cardia	or respiratory arr	est,	Approximate
	Physician		shock, or heart failure. List only o Immediate Cause (Final	AA _ I	ne.	L 5	1			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as	a consequence of):	W Porco	···			6 mintes
	Examiner		was a responsible from the second sec	lanne	ac Com					5 Years.
		ner	Sacual tally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):					
B	cuted	Examiner	that initiated events	c.	3					
o	e exe ian ai irial-t		resulting in death) Last	Due to (or as	a consequence of):					
68760, Ø	tificate be executed ig physician and as the burial-transit	edical		d						
			IF FEMALE:							
Вох	ath ca ttend or us	an/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	☐Ectopic pregnancy	/		23d. Date of delin	very Day Year
0	The law requires that the death centate has been signed by the attendinge 2 should be detached for use	Physician/N	1 ☐ Yes 2 🗖 No 9 ☐ Unknown	4□Pregnant at 9□ Unknown	time of death 5 [Other (specify)			Wight	Day Feat
σ.	hat the		Part II. Other significant conditions co	ntributing to death b	ut not resulting in the	inderhing cause ou	ron in Part I	23e Did tob	pacco use contribute to	the cause of death?
Vital Records,	w requires t been signe should be	d by			at not rooting in the	moonying cause giv	on in a dit.	1 X Ye		bably 4 Dunknown
Ö	requ been shoul	ete			-			1		
ž	has has	Completed						24a. Was a autops perform	v prior to c	opsy findings available ompletion of cause of
								1 ☐ Yes 2	No 1 ☐ Yes	2 No
₹		Be	25. Was case referred to medical examiner?	Hospital:		Oth	or /	th Check only on	170:	
οţ	Phy r this ral di	<u>و</u>	1 Yes 2 No 27. Manner of Death	1 Inpatie		nt 3LI DOA	4 V Nursing H	ome 5 Reside	ence 6 Other (Spec	(y)
Division	Attending in death.	ţi	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da)		Wor	k? Yes 2∐No	200. 2000100110	w injury occurred	
<u> S</u>	after death after death Director: In by the	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inju	ury - At home, farm, st			28f. Location (Sti	reet and Number or Rui	ral Route Number
ă	ai or A s after ni Dire ed in by	Certification:	4 Homicide	building, etc	c. (Specify)	,,,		City or Town		
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical (29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of the basis of and manner sta	examination and/or in	h occurred at the tin evestigation, in my o	ne, date and place pinion, death occu	, and due to the ca rred at the time, da	tuse(s) and manner as ate and place, and due	stated. to the cause(s)
	To the To the Comp	Me	29b. Signature and title of certifier			29c. License	e number	29	9d. Date signed (Month)	Day, Year)
	4) Ale	_	- MD	DI	774	3	11/3/01	9
	h		30. Name and address of person who co	ompleted cause of d	eath (Item 23a) (Type,	Print)	0 10	· · · · ·	200 4.0	2122
			L, SEENIVASAW	MD	300 1, Sil	TANOVER	2517 Ro	ALIIM.	one, My	21225
	Sta Registr	0.0	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature					
DWA	MH 17 Rev 1/20		NOV 0 8 2006	The second		WAC-				

DHMH 17 Rev 1/2001

		1 - For State Registrar	State of Maryla	nd / Depai <i>Cer</i> t	rtment of H Fificate of	Health and i <i>Death</i>	Mental Hy	rgiene 006	35171
Physic		Decedent's Name (First, Middle, Last) William Thomas	Baseman				2 Date of De Month Novemb	per 5, 2006	
/Med Exam		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, o	or Location of Deat		4c. County of D	·
		Greater Baltimore	Medical Cent	er	Towson			Baltimo	re
Funera Directo		213-07-0064	7. Age (In yrs	. last birthday) _ Yrs.	Months Days	If Under 24 Hrs Hours Min.	8. Date of Bi (Month, Da Feb.	rth ay, Year) 9. 8 22,1914	Birthplace (State or Foreign Country) Marvland
and		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Loca	ation		100		10d. Inside City Limits
r 28a-f show	tor	Maryland Baltimore		Towson					1 ☐ Yes 2X No
death with the Maryland death with the Maryland time 23a or 28a-f show	Director	10e. Street and Number 7001 N. Charles S	treet		10f. Zip Code	1204		10g. Citizen of What USA	Country?
i An i6 after death or iteme 2:	Funeral	11. Marital Status 1 Never Married 2 Married	2. Was Decedent Ever in the Armed Forces? 1 ☐ Yes 2 ☑ No		as Decedent of F Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puerl	pecify Yes or No to Rican, etc.)	0- 14. Race - Ai Black, W	merican Indian, hite, etc.
	þ	3 ☑ Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1[⊒Yes 2XXNo	Specify:		Specify: W	hite
1215-00 within 72 hourship and "ratural then "natural are Madical E.	Completed	15. Decedent's Educ (Specify only highest grade	completed)	16a. Decede (Give k. life. De	nt's Usual Occup ind of work done O NOT use retire	pation during most of word d)	rking	16b. Kind of Busines Amoco De	
ind 212. be filed withing that Hygiene. d other them	Comp	Elementary/Secondary (0-12)	College (1-4or 5+)		k Drive			ZINOCO DE	
laryland 212: 2 should be lied within and Mental Hygiene. Is marked other then summatic event, the Men	Be	17. Father's Name (First, Middle, Last)						, Maiden Sumame)	
Maryls Maryls d 2 should ih and Mer in and Mer 7 is marke	2	Earl Baseman 19a. Informant's Name/Relationship (Type	oe, Print)	19b. Mailing	Address (Street	·	ntgomer	Y er, City or Town, State	Zin Code)
and 2:		Diane Elizabeth Le	•						lvania 17361
Ore Total		20a. Method of Disposition ★XXBurial 2 ☐ Cremation 3 ☐ Re	amoval from State		atory or other pla		Date	20c. Location - City	
Baltimore, Me permit. Pages 1 and 2: Department of Health as Importent: if tem 27 is eny injury or other tra		4 □ Donation 5 □ Other (Specify) 21. Sign sture of Funeral Service License			ark Ceme	etery 11/	09/06	Woodlawn, 1	Maryland
Ball Ball Ball Ball Ball Ball Ball Ball		July B.	Denso	Bu	rgee-Her	nss-Seitz	Funera	l Home, Ind	g. 21211
التجرير		23a. Part1. Ther the disease, or complice shock, or heart failure. List only on		th. Do not enter	the mode of dyir	ng, such as cardiad	or respiratory a	rrest,	Approximate Interval Between
Physician /Medical	-	Immediate Cause (Final disease or condition resulting in death)	Premoc		Sep	515			3 days
Examiner			Due to (or as a conse	quence of):					
2 /2/ 5	ner l	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of):					
18760, cate be executed physicien and the burial-transit	Examin	that initiated events c.	Due to (or as a conse	quence of):					
18760, icate be exphysicien at the burials	dical	L d							
		IF FEMALE:	2-16						
Box 6 leath certifi attending	by Physician/M	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregn 1☐Live birth 2☐Fet 4☐Pregnant at time of	al death 3 □E	ctopic pregnancy	y		23d. Date of o Month	delivery Day Year
P.O. hat the de sid by the deteched	hysi	9 Unknown	9□ Unknown						·
ds, E		Part II. Other significant conditions cont Hellw + Failu		sulting in the und	lerlying cause giv	ren in Part I.			to the cause of death? Probably 4
ecor(law request been 2 should	plet						24a. Was		autopsy findings available
Vital Rec eicien: The law certificate hes t	Completed						auto perfo 1 Tes	ormed? death	
Vita sician certifi rector	Be	25. Was case referred to medical examiner?	ospital:		a□ co∧ Oth	26. Place of Dea			
Physeral disperse	n: To	27. Manner of Death	28a. Date of Injury	ER/Outpatient 28b. Time of	28c. Injur	y at		dence 6 Other (Sp how injury occurred	pecify)
sion (anding lath. or: After	atlo	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Intury	M 1 🗆	k? Yes 2∐No			
Division al or Attendia s after death. I Director: Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	iome, farm, stree ly)	t, factory, office		28f. Location (City or To	Street and Number or wn, State)	Rural Route Number,
Div To the Hospital or within 24 hours afte To the Funeral Dir completely filled in to	edical C	29a. Certifier 1 ertifying Physical Examination (Clinick only one)	ician: To the best of my know. On the basis of examination and manner stated.	owledge, death o ation and/or inve	occurred at the tir stigation, in my o	me, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
To the within 2 To the complet	Me	29b. Sig patere and title of certifier	n		29c. Licens	e number		29d. Date signed (Mo	nth, Day, Year)
		1			DSF	747		11/6/06	
15	J.	3 ame and address of person who cor	mpleted cause of death (Ite	m 23a) (Type, Pr	HARIE	\$ #202	BATTIN	rore mr	217114
S	tate	31. Date filed (Month, Day, Year)	32. Registrar's Sign			" 20)	1141	·01-01 1111,	
Regis		NOV 0 8 20	06	No Ale	Della B				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Love Bakhtiar AKA Paree Bakhtiar Blair 31, 2006 1:00 a October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospice Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days 1 □ M 2 🕅 F 577-42-6644 Director 74 Jan. 23, 1932 Iran Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Maryland Prince George's Lanham-Seabrook 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8583 Seasons Way 20706 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 1.5 Elementary/Secondary (0-12) Banquet Waitress Restaurant Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Abol Ghassem Bakhtiar Helen Jeffries 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shireen M. Blair - Daughter 8583 Seasons Way, Lanham-Seabrook, Maryland 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Washington National Cemetery 11/04/2006 Suitland, Maryland 21. Signature J Funeral Service 22. Name and Address of Facility Gasch's Funeral Home, P.A. deits 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Part1 shoc . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one pause on each line. Approximate Interval Between Onset and Death Immediat Cause (Final disease r condition **Physician** Sepsis /Medical resulting in death) Due to (or as a consequence of): Examiner Parkinson's Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Physician/Medical Examiner or Attending Physician; The law requires that the death certificate be executed as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE. 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? jo Month Day Year 5 Other (specify) 1 ☐ Yes 2 X No detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy perform 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: $_{4}\square$ Nursing Home $_{5}\square$ Residence $_{6}$ Nother (Specify) Hospice 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide

P.O. Box 68760. Division or Vital Records, s after death. 24 hours a Hospital

completely

within 2 the

Medical

Kanwaljit Nagi, M.D. 31. Date filed (Month, Day, Year) NOV 0 8 2006 Registrar

29b. Signature and title of certifier

29a, Certifier

(Check only one)



m.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/200

1 🖔 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

20056063

29d. Date signed (Month, Day, Year)

06-08374 Carol Butler Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene 35173 1- For State Certificate of Death Registrar 2. Date of Death . Decedent's Name (First, Middle,Last) Physician/ Month Day November 4, 2006 2115 hrs Carol Butler Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) N/A Baltimore Harbor Hospital Center 8 Date of Birth(MM/DD/YYYY) 9 Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs **Funeral** Foreign Months Days Hours Director 217 54 4762 Countr@anada 07/02/1945 1 M 2 X F Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location any 10a. State 1 X Yes 2 No or 28a-f show N/A Baltimore Maryland permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sht injury or other traumatic vecut, the Medical Examiner must be notified at once Director 10g Citizen of What Country 10e. Street and Number 10f. Zip Code 3616 - 7th Street 1st Floor 21225 U.S. 13 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Black 1 Never Married 2 Married Armed Forces? White, etc. 2 X No Yes Specify: White Yes, Give Year 1 Yes 2 X No specify: Widowed Divorced 2 or Dates 16b. Kind of Business/Industry Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Flementary/Secondary (0-12) College (1-4 or 5+) Steel Worker Baltimore, MD 21215-0036 Stee1 12th 18.Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Arthur Sherman Be Adeleine Campbell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a_Informant's Name/Relationship (Type, Print) Victoria Mann / Daughter 4805 Canvasback Drive Cambridge, Maryland 21613 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date 20a Method of Disposition 1 Burial 2 X Cremation 3 Removal from State crematory or other place) Bayview Crematory 11/07/2006 Baltimore, Maryland Donation 5 Other Specify: 22. Name and Address of FacilityGonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 001 Ritchie Highway Baltimore, Maryland 21225 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a, Part I. Enter the disease, or complication failure. List only one cause on each line. **Physician** Between Onset and /Medical Death Cocaine intoxication Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Lisease or injury that initialed events resulting in death) Last Due to (or as a consequence of) and Physician/Medical X UNPENDED AMENDED attending physician for use as the burial #23a,PII,27,28a-f,perME,g861,11/14/06 TI requires that the death certificate be Division of Vital Fecords, P.O. Box 68760, 23d Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 1 Live birth 3 Ectopic pregnancy Month Fetal death 2 past 12 months? 4 Pregnant at time of death 5 Other (Specify) i signed by the atte 1 Yes 2 V No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Yes 2 ✓ No 3 Probably 4 Unknown Hypertensive cardiovascular disease Completed Las been si 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe death? certificate Yes 2 V No Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Be Other₄ examiner? DOA Nursing Home 5 Residence 6 Other this 2 ٩ No 1 V Yes 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? After 27 Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 1 Natural 1 Yes 2 X No Pending 11/4/2006 8:20 pm Funeral Director: 24 hours after death. unknown Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3616 7th Street Baltimore, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 X Could not be 3 Suicide (Specify) home Baltimore. Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the one) and manner stated 29d Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie November 5, 2006 O.C.M.E 30 Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Tasha Greenberg MD. Assistant Medical Examiner

DHMH 17 Rev 1/2001 OCME 2006

State

Registrar

2006

Please Type or Print in Black Indelible Ink

enneth Benton		Sta 1- For State	ate of Maryland	/ Depa	rtment o			Hygiene	2	nn	6 3517
Physicia		Registrar 1. Decedent's Name (First, Middle	e.Last)	Cer	tificate of	Death		2. Date of Dea	teg 110.	0 0 1	3. Time of Death
ledical Exami		Kenneth Wayne H	Benton					Month Novembe	Day Ye	ear	0224 hrs
		4a. Facility Name (if not institutio St. Agnes Hospital	n, give street and number)			4b. City, Town, or Baltimore	Location of De	ath	4c. County	of Death	
Funeral Director		5. Social Security Number	6. Sex 7. Ag		ast birthday)	If Under 1 Year Months Day		Airo	,	Foreig	
Director		215-60-4021 Usual Residence of Decedent	1 X M 2 F	55	Yrs			May 2	1, 1951	Co	ountry) MD
* any		10a. State 10b. County			Town or Locat	ion				·····	10d Inside City Limits
Maryland 28a-f show 1 at once,	힕	MD N/A 10e. Street and Number		Balt	imore	10f. Zip Code		1.	10g. Citizen of V	Ihat Cou	1 Yes 2 No
th the Maryland 23a or 28a-f sho notified at once.	Director	2103 Eagle Stre	eet			21223		1	U.S.A.	mai çou	nuy:
th with ems 23	Funeral	11. Marital Status 1 XNever Married 2 Ma	12. Was Decedent Armed Forces?			I is Decedent of His es, specify Cubar		Specify Yes or No		e - Amer te, etc.	ican Indian, Black,
fter dea			1 X Yes 2 orced If Yes, Give Year	No.	1_x		specify:		Specify.	1-	ite
hours a	ed by	15. Decedent's Education (Spec			16a. Deceder	it's Usual Occupa ost of working life			16b. Kind of B	usiness/	Industry
5-0036 led within 72 hours a tygiene. other than "natura the Medical Exami	Completed	Elementary/Secondary (0-12)	College (1-4 or	5+)	Disabl	· ·		,	Disab	Led	
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		17. Father's Name (First, Middle, Joseph M. Bento			<u>l</u>			me (First, Middle,		e)	
212 ould be I Menta marke	To Be	19a. Informant's Name/Relations	Commence and Commence				et and Number	or Rural Route Nu	mber, City or To		e, Zip Code)
MD and 2 sho alth and 2 sho m 27 is		Joseph Benton/F	Brother	Look	t t	Lemmon S		Baltimor			
IOFE, iges la nt of He t: If ite		XBurial 2 Cremation			crematory or ot	her place)		Date 11-07-20	20c. Location	•	Maryland
Baltimore, permit Pages I ar Department of Hee Important: If ite	1	4 Donaftion 5 Other So		7			r			,	of Lansdown
	V	23a. Part I. Enter the disease, or	complications that causes	the death	27	'19 Hammo	onds Fe	rry Rd. I	Lansdow	ne M	
Physician /Medical		failure. List only one cause Immediate Cause (Final disease	on each line.						rest, shock, or h	eart	Between Onset and Death
Examiner		or condition resulting in death)	Due to (or as a cons			cic circio	Valocatar	diccipe			
Say were	je.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cons	equence o	f):						
dt =	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	equence o	f):						
e executed cian and irial - transit	dical E	X UNPENDED	d					······································			
	Medi	IF FEMALE:	AMENDED , 27 , 23c. If yes, outco	perML, me of preg	g864, 2	/12/07 TT			23d Date of	of deliver	у
Box 68760 e death certificate the attending physical for use as the br	sician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live birth	time of de		etal death 3 her (Specify)	Ectopic pre	gnancy	Month		Day Year
O. Box at the death 1 by the atte	Physi		known 9 Unknown								
P.O. es that the igned by	Ď	Part II. Other significant condit	tions contributing to deat	h but not r	esulting in the	underlying cause (given in Part I.				the cause of death? bably 4 Unknown
ords, P.O. w requires that is been signed b should be detar	ompleted							24a Was			utopsy findings available completion of cause of
Division of Vital Records, tal or Attending Physician: The law requirers after death al Director: After this certificate has been siled in by the funeral director; page 2 should be	Comp								ormed?	death?	·
/ital Rec ysician: The l nis certificate b	Be	25. Was case referred to medica examiner?	Hospital:	ent 2	ER/Outpatien		Other Nu	ck only one)	Residence 6	Othe	
n of Vit ding Physic After this	n: T	1 Yes 2 No 27. Manner of Death	28a Date of Inj. (Month, Day,	urv	28b. Time of	C 2	iry at Work?		how injury occu		
Sion Vitendi death ctor: 2	atio	1 X Natural 5 Pend 2 Accident Inves	ding stigation				Yes 2 No				
Divisipital or At ours after deral Direct filled in by	Certification:		ld not be rmined 28e. Place of Ir	njury - At h	ome, farm, stre	et, factory, office t	building, etc.	28f. Location or Town,		ber or Ru	ural Route Number, City
		29a Certifier (Check only 1 Certifying P	hysician: To the best of m		-				, ,		
To the Ho within 24 h To the Fu	Medical	one) 2 Medical Exa 29b. Signature and title of certifie	miner: On the basis of exa and manner stated er	imination a	ind/or investiga	29c. Licens		ed at the time, date	-		ne cause(s)
		11.111	K STO		λ	O.C.			Novembe		
		30. Name and address of person	V			444 D	D. !!!	NAD 0400			
<u></u>	ate	Theodore M. King, Jr. 31. Date filed (Month, Day, Year)		Medical E ar's Signati		TTT Penn St	reet, Baltım	ore, MD 2120	71		
Regis		NOV 0 8		1	· Since	K)					
DHMH 17 Rev 1/2	001				ORIGINA	L					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year WILLIAM BARDE 0,50 M 06 /Medical 6 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death BALTIMORE TED LENTER ASHINGTON / GLIN ર્વિ URNI Α. 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug. 23 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days ^{Yea}r) 1927 1⊠M 2□F Hours 082-20-9023 Director NY Usual Residence of Decedent 10c. City, Town or Location 10h County 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☑ No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 287 Eaglehill Road 21122 items 23a USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any Injury or other traument. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No White þ Specify: 3

Widowed 4 □ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Body Mechanic Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Barde Helen Neatherland Grace 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kathleen Ann Hartman (daughter) 287 Eaglehill Road, Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Nov. 07 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State MetroCrematory Inc. Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 2006 22. Name and Address of Facility 21. Signature of Funeral Service License Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** NEUMONIA JOURS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Jause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) be executed and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical The law requires that the death certificate 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a Division or Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ EVZOSCLEVZOSIS 2 No 1 ☐ Yes Completed 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy HYPERTENSION perform certificate 211 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ၉ 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) cause of death (Item 23a) (Type, Print) 30. Name and address of person

State Registrar RICHARD

31. Date filed (Month, Day, Year)

NOV 0 8 2006

egistrar's Signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 35176 Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month November 6,2006 2:00 A.M Blazucki Edward Milton 4b. City. Town, or Location of Death 4c. County of Death 4e Fecility Name (If not institution, give street and number) Oak Crest Care Center Parkville Baltimore Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex 1IXM 2□ F 85 Dec21,1920 219-07-9721 Maryland Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2 ☑ No Md. Baltimore Parkville 10g. Citizen of Whet Country? 10e Street and Number 10f. Zip Code 8800 Walther Blvd. Apt 2007 21234 USA 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1X Yes 2 No If Yes, Give Year or Dates: WW II 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3√2 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondery (0-12) 12th Banker Banking 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Felix Blazucki Catherine Poplar 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Marsha Bartholomew/daughter2313 Killoran Rd. Timonium, Md. 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition MBurial 2 ☐ Cremation 3 ☐ Removal from State Holy Rosary Cemetery 11/10 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, P.A. 21. Signature of Funeral Service Licens 1201 Dundalk Ave. Baltimore, Md. 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significent conditione contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 TYes 1 ☐ Yes 26. Place of Death (Check only one) Other: 41 Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA rsing Home 5 Residence 6 Other (Specify) 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation

Examine Division of Vital Records, P.O. Box 68760 Physician/Medical Completed by efter death.

Director: After this certifice d in by the funerel director, Be 2 Certification: filled in by To the Hospital or within 24 hours eff To the Funeral Di completely filled i

Physician

/Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

Director

21215-0020

Baltimore, Maryland

25. Was case referred to medical examiner? 1□Yes 2D No 27. Manna Deeth 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. (Check only one) 29d. Date signed (Month, Day, Year)

29c. License number

Normby 7th 2006

who completed cause of deeth (Item 23a) (Type, Print) 30. Name end eddress of person FADO TCAF Londomon

M

MD

State Registrar

Medical

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)
NOV 0 8 2006



State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 0 6 Certificate of Death 1. Decedent's Name (First, Middle, Last) NOVEMBER 4, 2006 Physician 10:22 A M BERLANSTEIN BELLE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE TOWSON 8415 BELLONA LANE #601 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05/20/1915 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Months NY 91 Yrs. 129-05-8620 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County if Itam 27 is marked other than "natural", or Itama 23a or 28a-1 show or other traumatic event, Ita Mudical Examinar must be inclified at 1 ☐ Yes 2 No TOWSON BALTIMORE Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21204 USA 8415 BELLONA LANE #601 Completed by Funeral Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iter important: If Item 27 is marked other than "natural", or iter any injury or other traumatic event, Ite Modical Exacultat Angle. 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. 3

Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) TOOL & DIE B00KKEEPER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ARANOVICH BARNETT SARA MEYER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 410 SYMPHONY CIRCLE - HUNT VALLEY, MD 21030 BRUCE BERLANSTEIN / 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ABurial /2 Cremation 3 Removal from State RANDALLSTOWN, MD BETH EL MEMORIAL PARK 11/6/2006 4 ☐ Donation 5 ☐ Other (Specify) o Fundal Servic Vicen 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Pairt. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death Immediate Cause (Final unu nuns Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, been signed by the attending physician should be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 □Unknown 1 Yes 2 No Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No page 2 s has 1 Yes 2 No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA မှ this After this funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Dav. Year) 29b. Signature and title of ce 027569 MO death (Item 23a) (Type, Print) 30. Name and address of no completed cause of 1838 2/200 Lenun 31. Date filed (Month, Day, Year) 32. Re State 8 2006 Registrar

		•	For State Registrar	State of Mar	-	epariment of r Certificate of t		Reg.	71116	35178
**	Physicia		Decedent's Name (First, Middle, Last)					2. Date of Death	Day Year	3. Time of Death
	Physicia /Medic	al -		Braxton		T		November	6th 2006	20.30 M
	Examin	er	4a. Facility Name (If not institution, give s				imore		4c. County of Dea	th
	Funeral		Union Memorial F 5. Social Security Number 6. Sex		In yrs. last birtho	ay) If Under 1 Year	If Under 24 Hrs.	B. Date of Birth	9. Bir	thplace (State or Foreign
į.	Director		212-56-4218 1 Dusual Residence of Decedent	M 2□ M F	53 Yrs	Months Days	Hours Min.	(Month, Day, Ye Nov. 20,	1952	MD
	yland now at		10a. State 10b. County	1	0c. City, Town o	Location				10d. Inside City Limits
	e Mar la-f sh tifled	ctor	MD N/A		Balti	more				1 ☐ Yes 2 ☐ No
	or 28	Director	10e. Street and Number			10f. Zip Code			Citizen of What Co	ountry?
	s 23a	ral	38 Exeter Hall A				1218		U.S.A	sion Indian
036	be filed within 72 hours after death with the Maryland Hydiene. ad other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	2. Was Decedent Ev Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	- 1	I3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ ₩o	an, Mexican, Puerto R Specify:	iry Yes or No- ican, etc.)	Black, Whit	e, etc.
215-0036	72 ho "natur dical I	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	1 (6	ecedent's Usual Occup live kind of work done	during most of working	16b	. Kind of Business	/Industry
7	within ene. than '	Jdmo	Elementary/Secondary (0-12)	College (1-4or 5+)		fe. DO NOT use retired	a)	R	estaura	nt
0	filed Hygid Sther ent, th		12th 17. Father's Name (First, Middle, Last)		1 00	JOK	18. Mother's Name			110
yland	ild be fental rked o	To Be	Lloyd Braxton	Sr.		:	Bes	sie M	itchell	
E.	s 1 and 2 should f Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (Typ		19b. M	ailing Address (Street	and Number or Rural	Route Number, Ci	ity or Town, State, .	Zip Code)
	and 2 ealth n 27 i		Danielle Braxto	n/Daught	er 58	322 Plume	r Ave. B			
saltimore,	Pages 1 a nent of Hea int: If item iny or othe		20a. Method of Disposition 1 Durial 2 □ Cremation 3 □ Re	ernoval from State		sposition (Name of crematory or other place			. Location - City or	
	it. Pa rtmer rtant: njury		4 Donation 5 Other (Specify) 21. Signature of Funeral Supplies		Mt. Z	ion Cemet 22. Name and Addre		5,2046	Baltimo	re, MD
g	permit. Pages Department of Important: If it any injury or o once.		21. Signatur	40		CALVIN	B. SCRUG	GS FUNE	RAL HOM	E
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused th	ne death. Do not	enter the mode of dyir	PRESTON ng, such as cardiac or	—ST BA respiratory arrest,	LTIMORE	Approximate
	Physician [*]		Immediate Cause (Final disease or condition	Λ /		Samueld				Interval Between Onset and Death
	/Medical		resulting in death)		consequence of):	301 60106	25/5			20 rears
	Examiner		Sequentially list conditions,		betes					10 Fears
7	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of)	/ / / 1		1	10	1 c Name
	xecut and al-trar	xan	that initiated events c. resulting in death) Last	Due to (or as a	consequence of):	structive	Lung	Diseas	(~	1318015
68/6 0,	rificate be executed ig physician and as the burial-transit		U d							
Q	tificat ng ph) as th	l edical	.= -=							
.C. Box	that the death cert ned by the attendin detached for use a	Physician//	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome pf 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death	3 □Ectopic pregnancy 5 □ Other (specify) _	у		23d. Date of de Month	livery Day Year
7	es that igned by be deta	by Pt	Part II. Other significant conditions con	tributing to death but	not resulting in th	e underlying cause giv	ren in Part I.	23e. Did tobac	co use contribute to	the cause of death?
ğ	w require been sig should b							1 Tes	2 No 3 P	robably 4 🗹 Unknown
Vital Records,	The larate has page 2	Completed						24a. Was an autopsy performed 1∐ Yes 2. ☑	prior to death?	utopsy findings available completion of cause of
<u> </u>	iclan certifi ector,	Be	25. Was case referred to medical examiner?	lospital:		atient 3000 Oth	26. Place of Death	(Check only one)		
ō	Phys r this ral dir	To	1 Yes 2 No	1 ☐ Inpatient	2 PER/Outpa 28b. Tim	Ment OLIDOA	4 Li Nursing Hom	e 5 Residence Bd. Describe how i	e 6 Other (Spe	ecify)
0	nding Fith.	ation	1 Action 1 5 ☐ Pending investigation	(Month, Day	Year) Inju	ıry Wor	rk? Yes 2 □ No		injury coodinou	
Division	r Attend er death rector: , by the f	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury building, etc.	/ - At home, farm (Specify)	, street, factory, office	28	Bf. Location (Stree City or Town, S	t and Number or R	ural Route Number,
5	pital or At ours after d leral Direc filled in by	Cert		1					, 	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier (Check only one) 1 ☐ Certifying Phys 2 ☐ Medical Examir	sician: To the best of ner: On the basis of e and manner state	examination and/o	leath occurred at the ti or investigation, in my o	me, date and place, a opinion, death occurre	nd due to the caus d at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	11.		29c. Licens	se number	29d.	Date signed (Mon	th, Day, Year)
			I Coleit X	A A	Hending	hysician D	005353	8 h	over bo.	6th 2001
	2		30. Name and address of person who co Robe PCT LINT	mpleted cause of dea	ath (Item 23a) (Ty	Do Drint)	memoria	1 170	SPITEL	, , ,
	Sta Registi		31. Date filed (Month, Day, Year) NOV 0 8 2	32. Registrar	's Signature	Sperk				

			For State	State of Marylai	nd / Department of Healtl **Certificate of Dea		2000	35179
			Registrar 1. Decedent's Name (First, Middle, Las	"	Continuate of Deal	2. Date of	_	3. Time of Death
	Physici: /Medic		Flora	Claibor	ne	Month	7ª - 200	6 5: 30AM
	Examin		4a. Facility Name (If not institution, give		109 4b. City, Town, or Location	on of Death	4c. County of Deat	h
			5. Social Security Number 6. Se	dallstown Li		Stown der 24 Hrs. 18 Date of B		ore County
	Funeral Director				Yrs. Months Days House	s Min. (Month,	Day, Year) 9. Bird	hplace (State or Foreigh untry) ARYLAND
	yland		10a. State 10b. County	10c. C	ity, Town or Location			10d. Inside City Limits
	e Mar	ctor	MARYLAND SALTI	MORE	WINDSO	R MILL		1 ☐ Yes 2 🖾 No
	ges 1 and 2 should be liled within 72 hours after death with the Maryland to f Heelih and Mental Hygiene. If item 27 is marked other than "natural", or Items 23s or 28s-f ehow or other traumatic event, it a Medical Examinar must be notified at	al Director	10e. Styleet and Number 2425 POTTE	ERSFIELD,	ROAD 10f. Zip Code	1244	10g. Citizen of What Co	untry?
	toms	Funeral	11. Marital Status	12. Was Decedent Ever in L Armed Forces?	J.S. 13. Was Decedent of Hispanic If Yes, specify Cuban, Mexi	Origin? (Specify Yes or can, Puerto Rican, etc.)	No- 14. Race - Ame Black, White	
21215-0036	hours afte	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 🔁 No Spec	ify:	Specify: BZ	LACK
5	in 72 "net leale	Completed	15. Decedent's Edi (Specify only highest grad	de completed)	16a. Decedent's Usual Occupation (Give kind of work done during n life. DO NOT use retired)	nost of working	16b. Kind of Business/	Industry
212	iene.	ошь	Elementary/Secondary (0-12)	College (1-4or 5+)	HOMEMAK	4	OWN H	OME
nd :	be filed tal Hygi d other event, I	Be C	17. Father's Name (First, Middle, Last)			other's Name (First, Midd	<u> </u>	
ylaı	should b and Ments marked	To	ARTHUR	K	AISON A	LICE "	BEAL L	OMAX
Maryland	12 short and risem.		19a. Informant's Name/Relationship (T	vpe, Print)	19b. Mailing Address (Street and Nur	mber or Rural Route Nun	mber, City or Town, State, 2	Zip Code)
	1 and Heeltl em 27		20a. Method of Disposition	/E5	Place of Disposition (Name of	Date /	20c. Location - City or	Town State
nor	Pages nent of int: If it		1 58urial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	cemetery, crematory or other place)	1110.01	B	or despession of
Baltimore,	- 등원수		21. Signature of Funeral Service Licens	1	22. Name and Address of F	11-10-00 pility Ba	11/14/	EAL HOME
Ö	Departing Department of the policy of the po		Withich,	N. Willia	m J9, 55 PNH F	ILTON AVE.	BAITO MI	21217
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the dea	th. Do not enter the mode of dying, such	as cardiac or respiratory	arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. Chronic	Obstructive Pu	1 monary	Disease	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec				
		-	Sequentially list conditions,	b. Due to (or as a consec	quence of):			
b	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events					
) (exec en an rial-tra	Еха	resulting in death) Last	Due to (or as a consec	quence of):			
68760,	tificate be executed g physicien and as the burial-transit	edical		d				
	ertific ling pl	Med	IF FEMALE:	20. 1				
Вох	attendin for use	ian	in the past 12 months?	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o	al death 3 Ectopic pregnancy		23d. Date of deli Month	very Day Year
P.0.	the d	Physician/M	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9 Unknown	Jean 3 Oner (specify)		-	
<u>ر</u> ت	The lew requires that the death cer site has been signed by the attendin page 2 should be detached for use	by PI	Part II. Other significant conditions co	ntributing to death but not re-	sulting in the underlying cause given in Pa	art I. 23e. Did	d tobacco use contribute to	the cause of death?
Division of Vital Records,	aquire en sig ould b	ed				10	Yes 2. 1 No 3 Pro	obably 4 Unknown
ecc	as be	pie				24a. Wt		topsy findings available completion of cause of
<u> </u>	The	Completed	(1810 - ESCHI TACK - ESCHI ST. 1813 - ES			pe 1 ☐ Yes	rformed? death?	2 □ No
Vita	Physician: r this certifice ral director, p	B	25. Was case referred to medical examiner?	Hospital:		ace of ath Check only		
ţ	Phys r this ral dir	2	1 Yes 2 No	1 Inpatient 2			esidence 6 Other (Species how injury occurred	cify)
O	Attending or death. ector: After by the fune	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	28b. Time of Injury 28c. Injury at Work? M 1 □ Yes 2		is now injury occurred	
<u>Visi</u>	Attendi ar death. ector: A by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h	nome, farm, street, factory, office	28f. Location	(Street and Number or Ru	ral Route Number,
	rs efter el Dire ed in b	Cert	TO TION DO	building, etc. (Speci		City or 1	Fown, State)	
	To the Hospital or Attending Physician: The lew requires that the death cer within 24 hours stefar death within 24 hours stefar death. To the Lunsel Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use	Medicai	29a. Certifier 1 Certifying Phy (Check only one)	sicien: To the best of my kno iner: On the basis of examina and manner stated.	owledge, death occurred at the time, date ation and/or investigation, in my opinion, o	and place, and due to the death occurred at the time	ne cause(s) and manner as e, date and place, and due	stated. to the cause(s)
	To the within To the comp	M	29b. Signature and little of certifier	ell n	29c. License number		29d. Date signed (Month	
)			pulmyly	1000, 11	10,1004 D005	6414	11-7-20	06
			30. Name and address of person who c	7 1 110	m 23a) (Type, Print)	L. D- 1 1	11-7-20 Randallstown	MN ausa
	Sta	to.	31. Date filed (Month, Day, Year)	Sayed, MD	ature	TY KOAA, #	Kanaanstowi	בכווא חואויי
	Registr			006	to Speed			
D	MH 17 Rev 1/20	001		1000	A PROPERTY OF THE PARTY OF THE			

Please Type or Print in Black Indelible Ink Kevin Patrick Caughey State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Rea. No Registrar 1. Decedent's Name (First, Middle,Last) Date of Death Physician/ Month Day November 3, 2006 Kevin Patrick Caughey 1124 hrs Medical Examiner 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 10583 Gateridge Road **Baltimore County** Cockeysville 5. Social Security Number If Under 1 Year If Under 24Hrs. . Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs last birthday **Funeral** Foreign 445-48-4644 Davs Hours Months 45 Director XXM 03-30-1961 Country) Ok 2 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d, Inside City Limits É Yes 2 X No 28a-f show Baltimore Cockeysville MD Pages 1 and 2 should be filed within 72 hours after death with the Maryland rector 10e. Street and Number 10g. Citizen of What Country s 23a or 28a-21030 USA 10583 Gateridge Rd. ö 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Yes -Specify: White 1 Yes 2 X No specify If Yes. Give Year Widowed Divorced ۾ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ Complet permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'injury or other traumatic event, the Medical Baltimore, MD 21215-0036 Self Employed Retail 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Patricia Nadine Norris John Lance Caughey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 Georgetown Woods Dr Youngsville NC 27596 John D. Caughey/brother 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery crematory or other place)
Chesapeake Crematory 11/8/06 1 Burial 2 X Cremation 3 Removal from State Beltsville, MD Donation 5 Other Specify 22. Name and Address of Facility 21-Signature of Funeral Service Licenses 8717 Green Pastures Dr Baltimore MD 21286 Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval **Physician** Retween Onset and /Medical Death Atherosclerotic cardiovascular disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed pue Physician/Medical X UNPENDED rial perME Division of Vital Records, P.O. Box 68760, the bur IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death Day Year ise as 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ρĵ ģ Yes 2 V No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26 Place of Death (Check only one) the Hospital or Attending Physician: examiner? Other₄ this Inpatient ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other. Scene 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural n 24 hours after death ie Funeral Director: A letely filled in by the fu 5 Pending 1 Yes 2 No Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) Homicide 29a Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started within 2 To the 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b Signature and title of certifie 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E. November 4, 2006 30. Name and ad ress of person who completed cause of death (Item 23a)

State

Registrar

Margarita Korell MD.

NOV 08

31. Date filed (Month, Day, Year,

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

2006

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

		For	Pleas	se Type or State o							Ensure A	-		_	ble.		
		1 - State Registrar					(Certi	ificate	of I	Death		Reg. N	o. O. O	00	0 =	
		1. Decedent's Nam	ne (First, Middle	, Last)								2. Date of D	eath	Z U	06	3. Time of	Dea(H)
Physic /Medi				Bet	tv	Louis	se C	offn	nan			Month Novemb		ay 2, 20	Year 0.6	9:50	A^{M}
Exami		4a. Facility Name (/	If not institution							wn, or	Location of Death	210 1 021130		c. County		3.30	
		Gilchris	t Hospi	ice					Tows				E	Balti	more		
Funeral		5. Social Security N	Number	6. Sex	7. Ag	e (In yrs.	last birth		If Under 1		If Under 24 Hrs.	8. Date of B			9. Birthpl	ace (State or	Foreign
Director		283-20-7	7357	1 □ M 2 💢 F		81	Υ	rs.	Months E	Days	Hours Min.	Oct 2	2, rear	925	Ohio	Ty)	
pu »		Usual Residence of 10a. State	f Decedent 10b. County			10- Cit	y, Town										
shov shov	2								uon						10	d. Inside Cit	-
he M	Director	MD	Howard	<u> </u>		Sar	vage	:								1 ☐ Yes	2 140
with 1		10e. Street and Nu		a					10f. Zip Co						/hat Count	ry?	
s 23	Funeral	8917 Was	ningtor	12. Was Dec	andont 5	Superio II	0 1	10.14/-	2076			" 14	U.S			1. 0.	
item item	Ę.	 Marital Status Dever Marr 	ried 2 Marri	Armed F	orces?		5.	I S. Wa	es, specify	Cuba	spanic Origin? (Sp in, Mexican, Puerto	ecity Yes or N Rican, etc.)	0-		e - America k, White, e		
ırs af Il', or xami	by	3 X Widowed	_	If Yes, G Year or E	ive	•0		1 🗆]Yes 2☐	No	Specify:			Specify	Whit	0	
2 hou	bed		15. Decedent	's Education			16a. [Deceder	nt's Usual C	Occupa	ation		16b. ł	(ind of Bu	siness/Ind		
7 nin 7. In "n Medi	ple	Elementary/Seco		t grade completed) College (.)	- ((Give kir life. DO	nd of work o NOT use r	done o retired	luring most of work)	ing	10			,	
d with giene gr tha	Be Completed		oridary (0 12)	1	(1-401-5	T)	Ma	nage	er				Re	tail	Groc	ery	
e file al Hy othe vent,	3e C	17. Father's Name	(First, Middle, I	Last)							18. Mother's Nam	e (First, Middle	e, Maide	n Surnam	e)		
uld b Ment Ment irked	2	Earl Mc	Everett	:							Bertha F	Rosquis	t				
2 sho and is ma		19a. Informant's Na	ame/Relationsh	ip (Type. Print)			19b. I	Mailing /	Address (S	Street a	and Number or Rur	al Route Num	ber, City	or Town,	State, Zip	Code)	
and seatth n 27		Louise H	lorner /	daughter/							ek Road,	New Wi	ndso	r, M	217	76	
of H		20a. Method of Disp		3 □Removal from	State	20b. P	lace of L emetery	Dispositi /, cremat	on (Name of tory or other	of er plac	e)	Date	20c. L	ocation -	City or Tov	vn, State	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		4 □Donation	5 Other (Sp	pecify)	Jiale	Sav	age	Cem	netery	Y	Nov 6	, 06	Sav	age,	Mary	land	
permit. Depart Import any Inj once.		21. Signature of Fu	uneral Service L	iconsee				22. N Don	lame and A	Addres	s of Facility Funeral H	lome, P	. A .				
<u>∞</u> □ = ≈ o		21. Signature of Funeral Service Licensee M00773 22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20												2070	7-4389	<u> </u>	
		SHOCK, OF HE	23a. Part1. Enter thy dilea y, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in tallury List only one cause on each line. Approximate Interval Between Onset and Death disease or condition Approximate Interval Between Onset and Death Sease or condition												/een		
Physician		disease or conditio	(Final	a \	10	LVI	AV	C	Anci	eR						Onset and D	eath 13
/Medical Examiner		resulting in death)		Due lo	(or as a	a consequ	uence of	f):								0	
Lxammer	L	Sequentially list co	nditions,	b													
ed isit	Examiner	Sequentially list co if any, leading to in Cause (Disease or	nmediate orlying injury	Due to	(or as a	a consequ	uence of	r):									
executed n and ial-transii	хап	that initiated events resulting in death) I	3	C	(or as a	a consequ	ience of	n.									
be icia bur				Duc to	(01 45 6	z oonocqt	JOHOC OI	.,.									
The law requires that the death certificate ate has been signed by the attending physioage 2 should be detached for use as the	Physician/Medical			d											_		
certif oding ise as	M/Me	IF FEMALE:		23c. If yes, ou	itcome i	of pregna	ncv							00-1-0-1-1			
atter after for u	ciar	in the past 12	months?	1 ☐Live	birth	2 ☐ Fetal time of de	death		ctopic pregr				Î	Mor	of deliver oth [,	ear
the d y the iched	iysi	1 ☐ Yes 2 ☐ 9 ☐ Unknown		9□Unkr		unio oi di	outi	000	their (Speen	.,,,							
w requires that the di been signed by the should be detached	F P	Part II. Other signif	ficant conditio	ns contributing to d	leath bu	t not resu	ılting in t	the unde	erlying caus	se give	n in Part I.	23e. Did	tobacco	use contri	bute to the	cause of de	ath?
quires n sign	d by						_					10	Yes 2	□No	3 ☐ Proba	bly 4 ∐Ur	nknown
s bee	Completed											24a. Was	an	24h W	lere auton	sv findings a	vailable
The la	E C											auto	psy ormed2	d p	rior to com eath?	pletion of car	
iling Physician: The lav n. After this certificate has funeral director, page 2 3	a	25. Was case refer	red to medical					_			26. Place of Death	1 Yes) 1	□Yes 2	No	
yslcl is cer direct	To B	examiner? 1 ☐ Yes 2 ☐	No	Hospital:	Inpatier	nt 2 🗆 I	ER/Outp	atient	3□ DOA	Othe				6 MOtho	r (Coonifu)	Ilm	
g Ph ter th	Ë	27. Manner of Deat		28a. Date	of Injur	у	28b. Tir	me of		Injury Work		28d. Describe			. , . ,	Moy	p.ce
ath. nr: Af	atio	1 ☑Natural 2 ☐ Accident	5 ☐ Pending investiga		iui, Day	rear)	1111	ury			es 2 □No						
I or Attend after death. Director: /	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could no determin	ned 28e. Place	of inju	ry - At ho . (Specify	me, farm	n, street	, factory, of	ffice		28f. Location (Street a	nd Numbe	r or Rural	Route Numb	er,
ital or its after a set or its after in led in	Se					. (-,)	,					Only of Yo	wii, Otali	=/			
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	cal	29a. Certifier (Check only	1 Certifying	Physician: To the xaminer: On the b	e best o	f my knov examinat	wledge,	death o	ccurred at t	the tim	e, date and place,	and due to the	cause(s) and mar	ner as sta	ted.	
the hin 2, the I the I the I	Medical	Giloy		and man	ner stat	ted.						od at the time					
S M S	2	29b. Signature and	title of certifier	1 1	0		1.0)			number				(Month, D		<u>,</u>
0		17/	Int	huy 1h		7 10					707				,	2006	
8		30. Name and addr	ress of person v	vho completed caus	se of de	ath (Item	23a) (Ty	ype, Prir	nt)	C/L	0 11	m 1	٠, ١	7 11			
		31. Date filed (Mon	th Day Year	G 3MC	Benistra	/01	/4 - (con	ullo	-/د	barro	· prid	c-1	- 0/			
Sta Registr	_	,		2000	iegisti d	, a Signal		Acon	80		Balto						
	004	N	0V 0 8	ZUUD /	PRIBA.	1 10	To A										

 $MRITCL_{o}$, CICUJeIIRS Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 13 per fh 9861 11-14-06 vt. State of Maryland / Department of Health and Mental Hygiene

Reg. No. 2005 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) November 6, 2006 **Physician** MARIA CRUJEIRAS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Franklin Square Hospital Rosedale Baltimore 7. Age (In yrs. last birthday)
R 4

Yrs

Months Days Hours Min. Octoor 1 29, 1995 22 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2**X** F 218-58-6140 Spain Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryla Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "naturel", or items 23s or 28s-f ehow emy injury or other traumatic event, If a Medical Examinar must be notified at once. Baltimore MD Baltimore 1 ☐ Yes 2 🔣 No Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8804 Wilson Avenue 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 1⊈Yes e∏ tho Specify: **Spanish** Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Residence Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 6 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Juan Martinez Rosa Folgar 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Juan Crujeiras-spouse 8804 Wilson Avenue-Baltimore, Maryland 21234 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other). 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State Parkwood Cemetery Parkville, Maryland 4 ☐Donation 5 ☐ Other (Specify) 11-10-06 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
EVANS FUNERAL
AND CREMATION 8800 Harford Road Parkville,MD 21234 CHAPEL SERVICES marge 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) INFARCTION **Physician** MINUTES ACUTE MYOCARDIAL /Medical Due to (or as a consequence of): Examiner DISEASE UNKNOWN CORDINARY VASCULAR ATTOMOSEL SPOTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical use es the IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 3 Ectopic pregnancy ŏ Month Day Year 5 Other (specify) should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, PNEUMONIA 1 Yes 2 No 3 Probably 4 □Unknown DIABETES MELLITUS TYPE 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 autopsy performe HYPERIENSION 1 ☐ Yes 2.5 No Division of Vital or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ■ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To this After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending 1 Tes 2 No М 24 hours after death. investigation the f 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hou To the Fune completely fil (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 040480 NOVEMBER 0 Zerro a ROAD 7602 BELATE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Formo, FERNANDO MD 21236 BALTIMORE, 20 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			1 - For State Registrer	State of Ma	aryland /	Depa <i>Cer</i>	artmer <i>tificat</i>	nt of H te of L	ealth an D <i>eath</i>	id Mer		giene leg. No		3518	3
	Physici		1. Decedent's Name (First, Middle, L William Bruce								Date of Dea Month VEMBE		ð6. 281	3. Time of Death 216 26:4219	ù.
	/Medic Examin		4a. Facility Name (If not institution, gi	ye street and number)	Cent	er	4b. City,	Town, or	Location of D	Death	n	4c.	County of Deal	ltimore	
Ī	Funeral Director		5. Social Security Number 6. 233-48-5585		e (In yrs. last i	birthday) Yrs.	If Unde Months	r 1 Year Days	If Under 24 Hours	Hrs. 8. Min.	Date of Birth (Month, Day V. 30	Year)	9. Bin Co 31 West	hplace (State or Foreignatry) Virginia	n
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Lo	cation							10d. Inside City Limit	
	a-1 eh	tor	Maryland Baltim	ore		Μ	liddl	e Rii	ver					1 □ Yes 2 N	0
	vith the	Directo	10e. Street and Number 8 Manifold Ct.				10f. Zip	Code 212	220			_	izen of What Co	ountry?	
	ns 23	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	13. V	Was Dece			? (Specify	Yes or No-		14. Race - Ame	nican Indian,	_
036	be filed within 72 hours after death with the Maryland tal Hygiene d other then "natural", or Items 23e or 28e-f ehow event, fre Medical Ezaminal must be notified at	ρ	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	10		fYes, spe I□Yes		spanic Origin n, Mexican, P Specify:	Puèrto Ric	an, etc.)		Black, Whit	e, etc. Ute	
215-0036	"natu	Completed	15. Decedent's f (Specify only highest g	ducation rade completed)	16	6a. Deced	dent's Usu	al Occupa	ition uring most of	f working		16b. K	ind of Business	Industry	
212	d withir r then r then	omo	Elementary/Secondary (0-12)	Coflege (1-4or 5	+)			Fitte				Mo	ichine S	Shop	
ם	be filed tal Hyg d othe	Be	17. Father's Name (First, Middle, Las	t)					18. Mother's				Sumame)		
<u> </u>	D 6 5 0	ဥ	Hugh Cramer 19a. Informant's Name/Relationship	(Type Print)	1	9h Mailin	na Address	s (Street a		garet		ith City o	or Town, State, 2	Zin Code)	
Z Z	alth an 27 le 127 le 1		Mary L. Cramer	(wife)			-		t., Mic						
Baltimore, Maryland 21	Pages 1 and 2 shoul nent of Health and Me int: If item 27 le marl iry or other treumati		20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3	☐Removal from State		tery, cren	natory or o	other place		Date			ocation - City or		
E	permit. Page Department of Importent: If eny injury or once.		4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice		Holl								timore, eral Ho	Maryland	_
n	Pen Pen Pen Pen Pen Pen Pen Pen Pen Pen		VILLE TELL	7 3		9	705	Belai	r Rd.,	, Bal	timor	e, N	1D 21236	nes i	
ı		SC 93	23a. Part1. Enter the disease, or conshock, or heart failure. List onl	y one cause on each lin	10.									Approximate Interval Between Onset and Death DECHDES	
	Physician / /Medical		fmmediate Cause (Final disease or condition resulting in death)	a Due to (or as	OSCLE		IC C	ARDI	OVASC	CULAI	R DIS	EAS	iE.	DECADES	
	Examiner		Sequentially list conditions	b	a consequent	D 0 01).									
	ed sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequenc	ce of):									
oʻ	ficate be executed g physicien and as the burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to (or as	a consequenc	ce of):									-
98760	cate be chysicia the bu	edical	•	d								-			
Box	ath certif	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal dea		Ectopic p Other (s _f						23d. Date of del Month	ivery Day Year	
, P.O.	res that lhe de signed by lhe s be detached f		Part II. Other significant conditions	contributing to death b	ut not resulting	g in the ur	nderlying o	cause give	n in Part f.		23e. Did to	bacco ı	use contribute to	the cause of death?	
ords	w requires been sign should be	ted by	HYPERTENSION								1 □ Y	es 2	□No 3□Pr	obably 4 Winknow	n
Division of Vital Records,		Completed								-	24a. Was a autop perfor 11 Yes	sy	prior to death?	itopsy findings availab completion of cause of 2 \(\text{No} \)	е
VIII	nysician: Th nis certificate director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 X No	Hospital:	-1 2 D E D	Outpatien		Othe	26. Place of				0. 000 (0.		
ion of	ing Ph After th uneral	ation; To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigati	28a. Date of Inju (Month, Da	ry 28t	b. Time of Injury		28c. Injury Work	4 🗆 1401311	28d	Describe h		6 □Other (Speny occurred	cify)	
Divis	al or Attend s after death il Director: /	Certifications	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	28e. Place of Injuding, etc	ury - At home, c. (Specify)	, farm, stre	eet, factor	y, office		281.	Location (S City or Town	treet an	nd Number or Ru	ural Route Number,	
	To the Hospital or Al within 24 hours after of To the Funeral Direc completely filled in by	edical (29a. Certifying F (Check only one)	thysicien: To the best miner: On the basis of and manner sta	examination	dge, death and/or inv	occurred vestigation	at the tim	e, date and p inion, death o	place, and occurred a	due to the cat the time, o	ause(s) late and	and manner as d place, and due	stated. to the cause(s)	
	To t withi Com	Σ	29b. Signature and title of certifier	30 her	MA		29	c. License	number 852		2		te signed (Mont	-	
ń	7		30. Name and address of person who			a) (Tyne	Print)	1/ 1.1	W w 155				11/7/	1006	
2	<i>y</i>		DAVID A BRIN	KER, M.D.	760	1 09	SLER	DRI	VE T	rows	ON, MA	RYL	AND 21	204	
1	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 8 2	32 Registr	ar's Signature	Gos	and I								

			1 - For State Registrar	State of Ma	ryland /	Departm Certific					2006	351	84
H	Physici /Medio		Decedent's Name (First, Middle, La James	st) U.		C	lark		2. Date of De Month	Day	2006	3. Time of De	eath M
	Examir		4a. Facility Name (If not institution, giv Future Care—Hor			4b. 0	City, Town, or Balti	Location of Dea	ath	4c.	County of Dea		
I	Funeral Director			7. Age	(In yrs. last b	Yrs. If U	hs Days	Hours Mir		ay, Year)	C	rthplace (State or Fountry) N.C.	-oreign
	Aaryland I show	or	Usual Residence of Decedent 10a. State 10b. County Md. NA			wn or Location						10d. Inside City 1⊈ Yes 2	
	vith the N	Direct	10e. Street and Number			Baltimor 10f	Zip Code			10g. Citi	zen of What C		
	or deeth v	Funeral Director	1337 E. North A	12. Was Decedent E Armed Forces?	ver in U.S.	13. Was D	21213 ecedent of His specify Cubar		(Specify Yes or No	D-	USA 14. Race - Am Black, Whi		
5-0036	be filed within 72 hours after deeth with the Maryland Hygiene. d other then "natural", or itema 23a or 28a-f show event, the Madical Examinar must be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 N If Yes, Give Year or Dates:			s 2 No	Specify:			Specify: B.		
က်	filed within 72 Hygiene. Ither then "nat out, the Medica	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ide completed) College (1-4or 5-		life. DO NO	Jsual Occupa f work done do Tuse retired)	uring most of w	rorking		nd of Business		
and 21	ild be filed viental Hygie ked other itc event, il	Be	7th grade 17. Father's Name (First, Middle, Last, James		lark,			18. Mother's Na	ame (First, Middle				
Maryland	2 should and N	T _o	19a. Informant's Name/Relationship (Type, Print)	19	b. Mailing Add			Rural Route Numb		r Town, State,		
			Carolyn Council 20a. Method of Disposition 1	Neio	20b. Place cemet	of Disposition (Name of or other place)	Date Date	20c. Lo	cation - City of		
a	permit. Pag Depertment Important: it any injury o		4 Donation 5 Other (Specif 21. Signature of Funeral Service Licer	-	Chape	el Hill 22. Name	Mem Ce		-9-06 March F.			l1, N.C.	
n	205 2 2		23a. Part 1. Enter the disease, or com	plications that caused	the death. Do				e., Balti		, Md.	21202 Approximate	
	Physician /Medical		shock, or heert failure. List only Immediate Cause (Final disease or condition resulting in death)	aDue to (or as a	and	Star	ge /	urlin	wns	Gu	euse	Interval Betwe Orfset and Dea	wwn
	Examiner	ıer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	consequence	e of):							
/60,	be executed sicien and burial-transit	al Examiner	cause. Enter underrying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a	consequence	e of):							
/89	rtificate t ng physi as the t	Medical	IF FEMALE:	d									
O. Box	at the death certificate by the attending phys tached for use as the	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at the 9 Unknown	Petal deal	th 3 □Ectop 5 □ Other	c pregnancy (specity)			2	23d. Date of de Month	livery Day Yea	ar
ecords, P.	as the	þ	Part II. Other significent conditions of	ontributing to death bu	t not resulting	in the underlyi	ng cause give	n in Part I.		obacco u Yes 2[o the cause of dea	
	0 - 0	Completed	<u> </u>	VA					24a. Was auto perfo 1 Yes	psy ormed2	death?	utopsy findings ava completion of cause	ailable se of
Vital	sician: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Other	-	eath (Check only	опе)			
on of	Attending Physician: r death. sector: After this certific. by the funeral director,	lon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day		Outpatient 3 Time of Injury	28c. Injury Work	at	Home 5 Resi			ecify)	
=	2 5 5 2	Certification:	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined		ry - At home, (Specify)	M tarm, street, fac		es 2 □No	28f. Location (City or To			ural Route Numbe	<i>f</i> ,
	To the Hospital of within 24 hours of To the Funeral D completely filled it	Medical C	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exar	ysician: To the best o niner: On the basis of and manner stat	examination a	ge, death occur and/or investiga	red at the time tion, in my opi	e, date and place nion, death occ	ce, and due to the curred at the time,	cause(s) date and	and manner a place, and du	s stated. e to the cause(s)	
)	To the within 2 To the complet	Me	29b. Signature and title of certifier	Mn			29c. License		69	29d. Date	signed (Mon	th, Day, Year)	
6			30. Name and address of parson who	completed cause of de) (Type, Print)	18	38	Green	e i	Tree	Rd zi	ws
*	Sta Registr		31. Date filed (Month, Day, Year)	32. Poistra	r's Signature	1	-						

			1 - State	eartment of Health and Me		2006 35105
	S. T. H.		Registrar 1. Decedent's Name (First, Middle, Last)		Reg. N 2. Date of Death	3. Time of Death
	Physici /Medic	al	A NNETTE M CO1 4a. Facility Name (If not institution, give street and number)	JLON Town or Location of Doub	NON O	Sec. County of Death
7	Examin	er	617 Douglas Street	4b. City, Town, or Location of Death Brooklyn Park		
21	Funeral	4	5. Social Security Number 6. Sex f 7. Age (In yrs. last birthday			Anne Arundel 9. Birthplace (State or Foreign
. 2	Director		003-52-0473 1□ M 2(DNE 50 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 1	956 Virginia
	pu &		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	ahor ehor	ō				1 ☐ Yes 2X No
	28a-1	Director	MD Anne Arundel Brooklyn 10e. Street and Number	10f. Zip Code	10a. C	Ditizen of What Country?
	3a or		617 Douglas Street	21225		USA
	ma 2:	Funeral		. Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R	offy Yes or No-	14. Race - American Indian,
9	within 72 hours after death with the Maryland ene. then "neturel", or itema 23a or 28a-f ehow fra Moulcal Examili or mail be notified at		Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ 2 ☐ 2 ☐ 2 ☐ 2 ☐ 2 ☐ 2 ☐ 2 ☐ 2 ☐ 2	1 ☐ Yes XX No Specify:	ecan, etc.)	Black, White, etc. Specify:
8	"neturel",	d by	3 Wildowed 4 Divorced Year or Dates:	whi		white
15-	n 72 ho "netur evice	lete	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)	g 16b.	Kind of Business/Industry
21215-0036	d within giene. or then	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 4 Compu	iter Specialist	U	.S. Government
b	oth oth ent.	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name ((First, Middle, Maide	en Sumame)
<u>Ia</u>		2	William Conlon	Yvonne G	Gallant	
Maryland	and and aum	12		ling Address (Street and Number or Rural		
	1 and 1 and 1 and 2 and 2 and 2 ther	10.9	Yvonne Conlon - Mother 617 20a. Method of Disposition 20b. Place of Disp	Dou las street Bro		ck, MD 21225 Location - City or Town, State
Baltimore,	2 to		1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State cemetery, cre	ematory or other place)		
i	permit. Pag Department Importent: It any injury o	i	4 □ Donation 5 □ Other (Specify) Metro Cr 21. Signatur, of Funeral Service Ligensee	22. Name and Address of Facility		Ltimore, MD
Ba	permit. Departr Importe any inje		Wim Machend	Cremation Society of 299 Frederick Road	of Marylar	nd, Inc.
	*		23a. Pagh. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition WI DELY MET)	ASTATIC CA E	3 REAST	Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):			J
8		7	Sequentiatly list conditions, if any leading to immediate Due to (or as a consequence of):			
	ansit A man	Examine	cause. Enter Underlying Cause (Disease or injury			
o,	exection and and rial-tra		that initiated events resulting in death) Last Due to (or as a consequence of):			
8760,	death certificate be executed et ettending physician and sider use as the burial-transit	dlcal	d			
9	entifica ling pl	Med	IF FEMALE:			
Вох	eath certific ettending p for use as	lan/	in the past 12 months?	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
o.	at the de by the tached	Physician/Me	1 U Yes 2 BUNO 9 Unknown			
s, P	The law requires that the site has been signed by the bage 2 should be detache.	by Pt	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
ords	w require been sig should b	ed t			1 ☐ Yes	2 No 3 Probably 4 Unknown
Vital Record	law re as be	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
H H		Con			performed?	death?
Vita	Physician: this certific ral director,	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death		SISTERS
of	Phys rthis ral di	5 T	1 Yes 2 No 1 Indigent 2 ER/Outpatie 27. Manner of Death 28a. Date of Injury 28b. Time	SIL 3 BOX 4 INDISING NOTE	e 5 Residence	110
lon	Attending Is death.	tlor	1 Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		
Division	al or Attendi atter death. I Director: A d in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined building, etc. (Specify)	treet, factory, office 28	8f. Location (Street City or Town, Sta	and Number or Rural Route Number,
Ö	ital or irs afte ral Dir led in	Cer	Sundaring, Stat. (Specify)		0.1) 0. 1 0.11.1, 0.10	
	To the Hospital of within 24 hours at To the Funeral D completely filled in	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basts of my knowledge, dea (Check only one) 2 Medical Examiner: On the basts of examination and/or and manner stated.	ith occurred at the time, date and place, ar nvestigation, in my opinion, death occurre	nd due to the cause d at the time, date a	(s) and manner as stated. Indiplace, and due to the cause(s)
	To th To th compl	Me	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
	/		Michel & A Smith w	D 2143	8 1	10V 06 2006
_	15		30. Name and address of person in completed cause of death (Item 23a) (Type M 1 CHARL J. Lg CVTA M 447) (Type		ANNAPOL	15 MD 21401
-E.	Sta Regist		31. Date filed (Month, Day, Year) 2006 32 Registrar's Signature	all)		

		,	For State	State of N	Marylan			nt of He te of D		•	gien Reg. N	2006	35186
			Registrar 1. Decedent's Name (First, Middle, Las	t)			imoa	0 01 0	- Catir	2. Date of De			3. Time of Death
	Physicia		LINDA		CLAR	rk				Novem		year year	6 1135 AM
7	/Medic Examin		4a. Facility Name (If not institution, give	street and number	r)		4b. City	, Town, or I	ocation of Deat	1		c. County of Deatl	
	<u> </u>	·	JOHNS HOPEINS BAYL	IEW MED	ELAL C	CENTIER	13,	ALTEM	ORE			N/A	
	Funeral		Social Security Number 6. Security Number	x 7. /		last birthday)	If Unde	r 1 Year Days	If Under 24 Hrs Hours Min.	8. Date of Bir (Month, Da	th ay, Year	9. Birtl	nplace (State or Foreign
ь	Director		214-54-5392	JM 2017	56	Yrs.				Dec. 4	, 19	949 Md	•
	and **		Usual Residence of Decedent 10a. State . 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
	Maryl f ehc	jo	Md. Balti	imore		Dunda	lk						1 ☐ Yes 2 🛣 No
	1 the	Director	10e. Street and Number	<u>-</u>			10f. Z	p Code			10g. C	itizen of What Co	untry?
	h with	ai D	2950 Sollers I	Point Ro	d. 21	222		2122	22			USA	
	deat	Funerai	11. Marital Status	12. Was Deceder Armed Force	nt Ever in U.	.S. 13. \	Vas Dece	edent of His	panic Origin? (S	Specify Yes or Noto Rican, etc.)	0-	14. Race - Ame Black, White	
9	or its	F	1 Never Married 2 Married	1 ☐ Yes 2 ☐				V	Specify:	to moun, oto.,			White
8	within 72 hours after death with the Maryland ene. than "ratural", or iteme 23a or 28a-f ehow the Mardical Exemitive must be notified at	d by	3 Widowed 4 Divorced	Year or Dates	:								
7	n 72	Completed	15. Decedent's Ed (Specify only highest grad	de completed)		16a. Deced (Give	tent's Usi kind of w DO NOT	ial Occupat ork done du ise retired)	ion iring most of wo	rking	16b. I	Kind of Business/l	ndustry
12	with iene than	mo	Elementary/Secondary (0-12)	College (1-4o	r 5+)			sitt			5	Sitting	Agency
ğ	e filed within al Hygiene. I other than vent. IIIE Ma	Bec	17. Father's Name (First, Middle, Last)							me (First, Middle	, Maide	n Sumame)	
<u>la</u> r	should be ind Mental I	To B	Parker L. Howa	ard					Edna	C. Bec	ker		
-	~ 4 4		19a. Informant's Name/Relationship (7										ip Code) 21222
	Health Health tem 27 other tra	H	Raymond Clark	Jr.	son				nip Rd.			Dundalk	
Baltimore,	ges 1 t of H if ite or ot		20a. Method of Disposition 1 🕅 Burial 2 □ Cremation 3 □	Removal from Stat	200. P	Place of Dispo emetery, cren K LAW	sition (Na natory or	ıme or other place ⊃ m	ov l	7. 7,		Location - City or	
ţ	t. Pa rtmen rtant:		4 □Donation 5 □ Other (Specify 21 Signature of Fuse at Service Licen		Ju				20	006	Ba	ltimore	2
Ba	permit. Pages 1 Department of H Important: If ite any injury or ot once.		21 September of Protectal Service Licent	-17		ğ	onne	nd Address ∋ <u>l</u> ly	Funera	ıl Home	Of	Dunda. 1222	lk
			23a. Part1. Enter the disease, or comp	olications mat caus	ed the deatl							1222	Approximate
	Physician		shoek, or heart failure. List only of Immediate Cause (Final										Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Press	as a conseq	uence of):							
	Examiner		Commentally list and distance	Oster									2 reaks
	D #	ner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a conse	uence of							
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c									
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	E		Due to (or a	is a conseq	uence oi):							
87	physic the t	dicat		d									<u> </u>
9 x 6	eath certific attending p	//Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	ne of pregna	ancy						23d. Date of deli	verv
Вох	death a atter	cia	in the past 12 months? 1 □ Yes 2 ☑ No	1□Live birth 4□Pregnant	at time of d		Ectopic Other (s	pecify)				Month	Day Year
0.0	at the de by the a tached	Physician/M	9 Unknown	9□ Unknown									
	es thai igned b	by P	Part II. Other significant conditions of	ontributing to death	but not resi	ulting in the u	nderlying	cause giver	n in Part I.				the cause of death?
ord	w requir been si should I	ted								1 🗆	Yes 2	2 □ No 3 □ Pro	bably 4 Whiknown
ec	law ras be	Completed								24a. Was	psy	prior to c	opsy findings available ompletion of cause of
E		Cou								1 Yes	ormed? 200 N	death?	2 No
Z.	Physician: this certific al director,	Be	25. Was case referred to medical examiner?	Hospital:		-		Othor		ath (Check only			
ō		٦.	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 🗀 Inpa		ER/Outpatien 28b. Time of		OA	4 Nursing F	fome 5 ☐ Res 28d. Describe		6 ☐Other (Spec	ıfy)
on	Attending F r death. ector: After by the funer	tior	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Ir (Month, L	Day Year)	Injury	м	28c. Injury Workî 1 ⊟ Y	es 2∐No		·	•	
Division of Vital Records,	alor Attendi after death. I Director: A d in by the fu	ifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of I	Injury - At ho etc. <i>(Specif</i>	ome, farm, str	eet, facto	ry, office		28f. Location (City or To		and Number or Ru	ral Route Number,
Ö	rs afteral Dire	Certification:											
	To the Hospitel or a within 24 hours after To the Funeral Direction completely filled in b	Medicai	29a. Certifier 1 Certifying Phyone) 2 Medical Exam	ysician: To the be- iner: On the basis and manner	of examina	wledge, death tion and/or in	occurre vestigatio	d at the time n, in my opi	, date and place nion, death occi	e, and due to the urred at the time,	cause(s) and manner as nd place, and due	stated. to the cause(s)
	To the within 2 To the complet	Mec	29b. Signature and title of certifier	and manner	Jaidu.		25	c. License	number		29d. D	ate signed (Month	, Day, Year)
	- s - ō		1-21	NO				ZES-	066			rember 3	
	Λ		30. Name and address of person who d		f death (Item	n 23a) (Type,	Print)		066		1000		,
	1		Jam Perti, Mo	494	G E	shern	Ave	•	Ballin	ore, MI	>	21224	
	Sta Registr		31. Date filed (Month, Day, Year)	32 Régis	strar's Signa	ture A	ACC D					21224	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 31 per dvr 9861 11-8-06 vt State of Maryland 7 Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Cottman Month **Physician** 2006 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Pembridge Avenue Battimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days 214.64.8607 Months Hours 1 □ M 2 X F MD 06.28-1954 Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notitled at once. MD Baltimore N/A 1 XYes 2 □ No Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21215 5119 Pembridge USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black Completed by 3₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Health Care Elementary/Secondary (0-12) College (1-4or 5+) Duty Nurse 12th grade year 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cottman Katie L. Phifer Momas ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2507 Strathmore Avenue Balto. MD Hughes NICOLE Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) greenmount Crematory 11.02.06 Baltimore, MD 2. Name and Address Facility allimn C. Grene Funeral Services 1905 York Koad Bathmore MD 21212 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 55 druid **Physician** N904C 0 /Medical Due to (or as a consequence of) Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) After this certificate has been signed by funeral director, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy 1∐ Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Many of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. of certifier 29b. Signature and ti 29d. Date signed (Month, Day, Year) 001)[10] 30 Name and address of person who completed cause death (Item 23a) (Type, Print) Year) NOV 31. Date file (Month, Day, State Registrar

06-08313 Gene R. Carr

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 35188

	1- For State Registrar	Cer	tificate of	Death		Re	g No 200	0 3310		
Physician/ Medical Examiner	1. Decedent's Name (First, Middle	Gene Raymond	l Carr	,	2	2. Date of Death Month November	n Day Year	3. Time of Death 1751 hrs		
	4a. Facility Name (if not institution 47 Mulard Court	, give street and number)	4	b. City, Town, or L Severna Par			4c. County of Death Anne Arundel			
Funeral Director		5. Sex 7 Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24Hrs. Hours Min.	8. Date of Birti	Со	thplace (State or Foreign untry) st Virginia		
w any	Usual Residence of Decedent 10a State 10b. County	10c. City,	Town or Location	on		10/20/1	1930 Wes	10d. Inside City Limits		
-f sho		Arunder ba.	ltimore					1 Yes 2 X No		
h the Maryland 3a or 28a-f sh otified at once	10e Street and Number 119 Bon Air A	venue		10f. Zip Code	1225	. 10	Og Citizen of What Cour	ntry?		
21215-0036 Ple filed within 72 hours after death with the Maryland Mental Hygiene. narked other than "natural", or items 23a or 28a-f show any event, the Medical Examiner must be notified at once. O Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Mar 3 X Widowed 4 Divo	12. Was Decedent Ever in U. Armed Forces? 1 X Yes 2 No roed If Yes, Give Year	If Ye		panic Origin? (Spe Mexican, Puerto R		14 Race - Ameri White, etc.	can Indian, Black,		
urs aft tural" amine d by	15. Decedent's Education (Speci	or Dates:	16a. Decedent	's Usual Occupation	on (Give kind of wo		16b. Kind of Business/I			
21215-0036 hould be filed within 72 hours after the Mernal Hygene. is marked other than "natural", rife event, the Medical Examiner. To Be Completed by 1	Elementary/Secondary (0-12)	College (1-4 or 5+) 2 years	_	st of working life. I s Manage:	DO NOT use retire r	d)	Commercia	1		
5-0C ed wit tygien other	17. Father's Name (First, Middle, L			18	8 Mother's Name (
121 l be fil ental P arked vent, l		Randolph Carr	5-00-5-10-034			e Wilfor				
shou and 77 is natic	19a Informant's Name/Relationshi Michael Carr /	Son	119	Bon Air A	Avenue	Balti	ber, City or Town, State more, ${ t Maryl}$	and 21225		
ore, MC ss 1 and 2 st of Health an If item 27 her trauma	20a. Method of Disposition 1 Burial 2 X Cremation		Place of Disposi crematory or oth	tion (Name of ceme er place)	etery,	Date	20c. Location - City or	Town, State		
. ⊑	4 Donation 5 Other Spe	Bay	view Cr			06/2006	Baltimore,	Maryland		
Baltimore, M permit Pages I and 2 Department of Health Important: If item 2 injury or other traum	21. Spature of Funeral Service L	landge	22. N 400	ame and Address o	^{of Facility} Gond e Highway	ce Fune: Balti	ral Service more, Maryl	P.A and 21225		
Physician /Medical	23a Part I. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approxim Between									
xaminer	Immediate Cause (Final disease or condition resulting in death)	a Hypertensive athe Due to (or as a consequence of		cic cardiov	ascular di	sease		Death		
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b. Due to (or as a consequence of	f):							
ted nsit Exami	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	f):							
8760, ificate be executed ig physician and is the burial - transit n/Medical Examiner	X UNPENDED	AMENDED #23a,PII,2		g861 , 11/17/	06 TT					
certificate be nding physici as as the buri	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregr	nancy 2 Fet	al death 3	Ectopic pregnance	cv	23d Date of delivery Month	ay Year		
of Vital Records, P.O. Box 687 ing Physician: The law requires that the death certificate has been signed by the attending luneral director, page 2 should be detached for use as in: To Be Completed by Physician	past 12 months? 1 Yes 2 No 9 Unkn	Pregnant at time of dea	oth	er (Specify)			i i			
O. I.		ons contributing to death but not re	esulting in the ur	nderlying cause giv	ven in Part I.		pacco use contribute to			
S, P.(irres that a signed d be det ed by	Lung Disease					1 Yes	2 No 3 Prob	ably 4 Unknown		
Records, The law require are has been signage 2 should b						24a, Was a autops	y prior to c	opsy findings available ompletion of cause of		
Rec The liftcate h						perform 1 ✓ Yes 2		s 2 No		
f Vital Physician: er this certif	25. Was case referred to medical examiner?	Hospital:		-	of Death (Check or					
n of Villing Phys After this funeral di	1 ✓ Yes 2 No 27. Manner of Death	I Inpatient 2	ER/Outpatient 28b. Time of In		Other 4 Nursing		Residence 6 Other	Scene		
	1 Natural 5 Pendir				es 2 No		- · · · · · · · · · · · · · · · · · · ·			
Division of Vital Records, P.O. Division of Vital Records, P.O. spital or Attending Physician: The law requires that towns after death. neral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detac Certification: To Be Completed by F	2 Accident Investi 3 Suicide 6 Could determ	not be 28e. Place of Injury - At ho	ome, farm, stree	t, factory, office bu	ilding, etc. 2	8f. Location (St or Town, St	treet and Number or Rui ate)	al Route Number, City		
O Till Bill O	29a. Certifier (Check only) Certifying Phy	vsician: To the best of my knowledg								
To the Ho within 24 To the Fu To the Fu Completed	one) 2 ✓ Medical Exam 29b. Signature and title of certifier	iner:On the basis of examination ar and manner stated		29c License		ne time, date a				
Nong. 5	Josha	Jeef MD		O.C.M			November 3, 200			
18/4	Tasha Greenberg MD.	ho completed cause of death (Item Assistant Medical Exami		Penn Street, B	Baltimore, MD	21201				
State Registrar		2006 32. Registrar's Signatu	A Ans	W.	-					

State of Maryland / Department of Health and Mental Hygien 👂 🧻 💍 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Odia Mae Compton November 2006 9:30 A. M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 107 West Clement Street Baltimore N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex 8. Date of Birth (Month, Day, Year) June 4, 1925 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 □ M 2 🖾 F 220 18 1821 81 Yrs. Director Mary Tand Usual Residence of Decedent 2 should be filed within 72 hours after death with the Marylend and Mental Hyglene. Is marked other then "naturel", or Iteme 23a or 28a.4 show 10a State 10h Count 10c, City, Town or Location 10d. Inside City Limits Item 27 is marked other then "naturel", or Items 23a or 28s-f show other treumatic event, the Madical Examinar must be notified at N/A Baltimore 1 Yes 2 □ No Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 107 West Clement Street U.S. 21230 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 20 No Specify: Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 9th College (1-4or 5+) Restaurant Restaurant Staff 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George W. Bowers Bessie (not available) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If Item 27 is rr any injury or other treum <u>once.</u> Lily Martin / daughter 3821 White Oak Court Manchester, Maryland 21102 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park 11/09/2006 Glen Burnie, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign to of Funeral Service Lig 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the beath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical Examiner STRUCT Scuartially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit the attending physicien and thed for use as the burial-tran Due to (or as a consequence of): Box 68760. certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. been signed by the should be detach-Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan certificate has autopsy performed? 2 No 2 No 1 Yes 1 Tyes Hospitel or Attending Physicien:
 24 hours after death,
 Funerel Director: After this certifice 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 0 1 Inpatient 2 ER/Outpatient 3 DOA the funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Vithin 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SONER 1147 us MARC 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar NOV 0 8 2006

			1 - For State Registrer	State of Man	yland				ealth a	and M		gienę Reg. Nd	71116	35	190
	Physicia /Medic	al	DELORES ANN 4a. Facility Name (If not institution, give st	CUNNING	HAM		4b. City.	Town, or	Location o	of Death	2. Date of De Month NOVEMBE	R C	y Year 06, 2006 County of Death	3. Time o	
	Examin Funeral	er	UNION MEMORIAL 5. Social Security Number 6. Sex	HOSPITAL	'n yrs. la:	st birthday)	B.	ALTI	MORE	24 Hrs.	8. Date of Bird	<u> </u>	N/A	piano /Stato	or Foreign
	Director		Usual Residence of Decedent		63	Yrs.	Months	Days	Hours	Min.	JAN. 2	, Year) 2 , 1	943WES		GINIA
	h the Marylan or 28a-f show	ector	10a. State 10b. County N/A	10		Town or Lo	EMOR:								ity Limits Dity Limits
	with t	Dir	10e. Street and Number 35 N. LAKEWOOD	AVENUE			10f. Zip	212	24			10g. Cit	tizen of What Cou		
036	hours after death with the Maryland Lural', or Itema 23a or 28a-f show al Ezatra at must be multified at	by Funeral Director		2. Was Decedent Eve Armed Forces? 1 ☐ Yes 2√√No If Yes, Give Year or Dates:	er in U.S.	i	Was Dece f Yes, spe	dent of Hi cify Cubai		gin? (Spe , Puerto	ecify Yes or No Rican, etc.)		14. Race - Ameri Black, White	can Indian,	
215-003	within 72 ho ene. then "netur te Medicel	Completed	15. Decedent's Educ (Specify onfy highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)		life. I	kind of wo DO NOT u	rk done a se retired,	lurina most	t of worki	ng	16b. K	ind of Business/Ir	ndustry	
2	iled wi Hygien ther th	Con	8 17. Father's Name (First, Middle, Last)			W	AITR	ESS	18 Mothe	r's Name	(First, Middle,	Maiden	BAR Sumame)		
Maryland	iould be f Mental P marked of matic ava	To Be	FLOYD GIBSON	MILLS					ANN	IA	JANE	STC	TTLER		
Ma	id 2 sh lth and 27 is m treum		19a. Informant's Name/Relationship (Type DARLEEN MYERS/S				-						or Town, State, Zi RE, MD.		
lore,	iges 1 and of Healt of Healt or other		20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Re	emoval from State	20b. Pla	ice of Dispo	sition (Name	me of other place	9)	C	Date	20c. Lo	ocation - City or T	own, State	- 1
Baltimore,	permit. Pag Department Important: any njury o		4 Donation 5 Other (Specify) 21. Signature of Funeral Convice License		BAY	VIEW 2Î		od Addres	ZEIL	ER	INC. F	UNE	TIMORE CRAL HOI CIMORE,	ME	1231
, '09 , '09	Physician /Medical Examiner	cal Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e cause on each line. KIEDSE Out to (or as a c Due to (or as a c Medias	Ila onseque	Do not ent		de of dying						Approxima interval Be Onset and I MOI	te tween
.O. Box 687	at the death certificate by the attending physi teched for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ØNo 9 □ Unknown	ic. II yes, outcome of a 1 Live birth 2 Live birth 2 Live Bregnant at tim	Fetal	death 3	Ectopic p						23d. Date of deliv Month	,	Year
Ω,	uires that I signed by lid be dete	þ	Part II. Other significant conditions conf	tributing to death but n	not result	ting in the u	nderlying	ause give	n in Part I.			obacco i	use contribute to		death? Unknown
al Records,	: The law requires that the cate hes been signed by th page 2 should be deteche	Completed											death?	mpletion of	
Vital	nysician: Th	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	ع ٦٦ =	R/Outpatien	t 3[] D(Othe	\C		(Check only o		6 ☐Other (Speci	4.1	
Division of	ding Pt n. After th funeral	-	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Y	2	28b. Time of Injury		28c. Injury Work		:	28d. Describe h			ī y)	
Divis	al or Attano atter deatt Director: d in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (- At hom Specify)	ne, farm, str	eet, factor	y, office			28f. Location (5 City or Tox		nd Number or Rur e)	al Route Nur	nber,
	To the Hospital or Al within 24 hours after of To the Funers! Direct completely filled in by	Medical C	29a. Certifier 1 Certifying Physic (Check only one)	icien: To the best of n er: On the basis of ex and manner stated	caminatio	ledge, death on and/or in	occurred vestigation	at the tim	e, date and pinion, deat	d place, a	and due to the ed at the time,	cause(s)) and manner as : d place, and due !	stated. to the cause(s)
	To the within 2 To the complet	M	29b. Signature and the of certifier				29	c. License	number	- 11		29d. Da	te signed (Month,	Day, Year)	
•	1			, M.D.			F	T2	1389	744	2	Nou	IEMBER (1,200	16
	1		30. Name and address of person who cor	25, MID.	Ur	าเอก	Print) Mel	nari	al H	10sf	rital,	M.			
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's	Signatu	Ire	Ange.	80		9					

			1 - For State Registrar	State of Maryland		ent of Health	th	Reg. M	711116	35191
	Physic /Medi Exami	cal	Decedent's Name (First, Middle, Last) CSS/R CR 4a. Eacility Name (If not institution, give s	AW FORD	4b. (City, Town, or Location		2. Date of Death Month Da	Year 1 - 2006 County of Death	
	Funeral Director	lei	5. Social Security Number 6. Sex	ikesville		nder 1 Year If Und	SVILE ler 24 Hrs.	8. Date of Birth (Month, Day, Year	Baltin 9. Birth	n ore place (State or Foreign ntry)
	within 72 hours after death with the Maryland ene. then "naturel", or Items 23a or 28a-f show hs Medical Examinat must be notified at	Director	10a. State 10b. County	10c. City,	Town or Location Bali	Linzore				10d. In side City Limits 1 Yes 2 □ No
	leath with the ns 23a or 2 must be ns	Funeral Dire	10e. Street and Number 5825 Grist 11. Marital Status	Ave 2. Was Decedent Ever in U.S		Zip Code 2/2/	5 Origin? (Spec		itizen of What Could the C	2
9800	nours after d urel', or iten I Examiner	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates:	If Yes,	ecedent of Hispanic specify Cuban, Mexi s 2000 Speci		ican, etc.)	Black, White,	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 Ie marked other then "naturel", or Items 23a or 28a-f show other traumatic event, The Medical Examinar must be notified at	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		16a. Decedent's l (Give kind o life. DO NO	f work done during m T use retired) A _ I N		9	(ind of Business/In	dustry
Maryland	should be filed nd Mental Hygis marked other umatic event, I	To Be C	17. Father's Name (First, Middle, Last) Leomrd Crou 19a. Informant's Name/Relationship (Ty)	u Jord	10h Mailin Add	Co	ora F	First, Middle, Maider		
_	s 1 and 2 sho f Health and item 27 le ma other traum	,	Josephine Crac 20a. Method of Disposition		5825	GiS+ AV	-	Route Number, City Finzorc te 20c. L		1215
Baltimore,	permit. Pages Department of Important: If it eny injury or o		1 Maurial 2 □ Cremation 3 □ R. '4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License		Tarrisor 22. Names		11.9.6	Acolo Ou	virrys in	nb nid nal Servier mo 21133
	Fnysician /Medical		23a. Part1. Enter the disease, or complishock, or heaft failure. List only on Immediate Cause (Final disease or condition resulting in death)		Do not enter the	mode of dying, such			Lotan	Approximate Interval Between Onset and Death
8760,	sate be executed shysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque						
.O. Box 6	death certific e attending p od for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ac. If yes, outcome of pregnand 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of dea 9 □ Unknown	leath 3□Ectopi	c pregnancy (specify)			23d. Date of delive Month	ery Day Year
s, P	ires tha signed d be de	by	Part II. Other significant conditions con	ributing to death but not result	ing in the underlyir	ng cause given in Pai	rt I.	23e. Did tobacco	use contribute to th	
Vital Record	The ate h page	Completed						24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No	prior to cor death?	psy findings available inpletion of cause of
of	Attending Physician: Thr death. ector: After this certificate by the funeral director, pag	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No H. 27. Manner of Death 1 Natural 5 Pending investigation	ospital: 1 Inpatient 2 El	R/Outpatient 3 8b. Time of Injury	Garage Contract	Nursing Home	Check onl one 5 ☐ Residence d. Describe how injure		r)
Division	in Diffe	Certifica	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, street, fac	tory, office	28	f. Location (Street ar. City or Town, State	nd Number or Rura a)	l Route Number,
	To the Hospital within 24 hours a To the Funerel Completely filled it	edical	one)	cian: To the best of my knowler: On the basis of examination and manner stated.	ledge, death occur on and/or investigat	red at the time, date tion, in my opinion, d	and place, an eath occurred	d due to the cause(s) at the time, date and) and manner as st d place, and due to	ated. the cause(s)
)	To To com	M	29b. Signature and title of certifier	4e		29c. License numbe		29d. Da	te signed (Month, I	Oay, Year) 6 (2006)
	17		30. Name and address of person who con Daharah I PLGY 31. Date filed (Month, Day, Year)	npleted cause of death (Item 2	(Type, Print)	ights A	enu	s Bald	more	6,2006 M) 21208
	Sta Registr		NOV 0 8 2	32. Redistrar's Signatur	15. 1596	56				

		1	For State Registrar	State of Maryland		rtment of H tificate of I		lental Hygier Reg. I		00172
- 4			Decedent's Name (First, Middle, Last)					2. Date of Death	Day Year	3. Time of Death
	Physicia /Medic		David Alex	ander Cr	ouch,			November	$c^{-}4,2000$	
	Examin		la. Facility Name (If not institution, give st			4b. City, Town, or	r Location of Death		4c. County of Deat Harford	
\$. 	E		1600 Redfield R	oad 7. Age (In yrs. la	ast birthday)	If Under 1 Year	r If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	Q Rie	hplace (State or Foreign
Ď.	Funeral Director		214-54-2244	M 2□F 58	Yrs.	Months Days	Hours Min.	July2,19	948 M	aryland
	and w	-	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Loc	ation				10d. Inside City Limits
	Maryi II eho	tor	Md. Harfor	d	Be]	L Air				1 ☐ Yes 2 🙀 No
	or 28a	Olrec	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	ountry?
	e 23a	ral	1600 Redfield R	.oad 2. Was Decedent Ever in U.:	S 13 V		015	ecify Yes or No-	USA 14. Race - Ame	nican Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show stripling or other traumatic event, Ite Moulcal Examinar most be notified at anote.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Black, Whit	
200	72 hou	eted	15. Decadent's Educ (Specify only highest grade	ation completed)	(Give	lent's Usual Occup kind of work done	during most of work	ting 16b	. Kind of Business	/Industry
121	within ine.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		oo NOT use retired er Read	•	T	BGE	
Q 2	filed v Hygie other i	Be Co	17. Father's Name (First, Middle, Last)	3913	110 00	I Read		e (First, Middle, Maid		
/lan	uld be Mental Irked	To B	Emerald Crouch				Anna Ve			
Maryland 21215-0036	alth and I		19a. Informant's Name/Relationship (Type Susan Crouch (W				ld Rd. H	al Route Number, Ci Bel Air,	Maryla	nd 21015
Baltimore,	ages 1 a ent of Hei ht: If item y or othe	1	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)			sition (Name of natory or other pla islaus			Location - City or	
Baltin	permit. P Depertment importarient in in in in in in in in in in in in in		21. Signature of Funeral Service License		22	. Name and Addre	ss of FacilityKaC	zorowsk: e. Baltin	i Funera	al Home, PA
	DATE		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death	n. Do not ent	er the mode of dyi	ng, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
Ų.	Physician		Immediate Cause (Final disease or condition resulting in death)	Glioblas	tom	a Mu	utitor	me_		14 months
	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):		1			
3		Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq	uence of):					
	nd And Itansit	Examln	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
8760,	ficate be executed physicien and the burial-transit	al Ex	resulting in deality cast	Due to (or as a conseq	uerice oi).					
687	ficate p phys	edical	_ d	•						
Box	The law requires that the death certificate be executed as been signed by the attending physicien and age? should be detached for use as the burial-transit	Physician/Me	in the past 12 months? 1 Pyes 2 No	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	ideath 3□	Ectopic pregnanc Other (specify)	у		23d. Date of de Month	olivery Day Year
P.0	that the de ed by the detached		9 ☐ Unknown Part II. Dther significant conditions con		ulting in the u	nderlving cause gr	ven in Part I.	23e. Did tobac	co use contribute t	o the cause of death?
rds,	w requires the been signers should be considered.	ed by	Partiti Dation digitalization della					1 ☐ Yes	2 1 No 3 □ P	robably 4 Unknown
Records,	The law resete has be	Completed						24a. Was an autopsy performed	prior to d? death?	
Vital	Physician: The this certificete ral director, pag	Be	25. Was case referred to medical examiner?	lospital:		Ot	har	th (Check only one)		
of	Phys this ral di	on: To	1 ☐ Yes 2 ☒ No 27. Manner of Death 1 ☒ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Inju	ry at ork?	lome 5 XResidence 28d. Describe how		ecify)
Division	or Attending after death. Director: After in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specia	ome, farm, st		Yes 2 No	28f. Location (Stree City or Town, S		Rural Route Number,
Ω	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Medical Ce	29a. Certifier 1 Certifying Physical Check only 2 Medical Exemi	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, deat ation and/or in	h occurred at the to	me, date and place opinion, death occu	and due to the caus rred at the time, date	se(s) and manner a and place, and du	is stated. le to the cause(s)
	ro the vithin 2 To the comple	Mec			\	29c. Licen	se number	29d	. Date signed (Mor	nth, Day, Year)
	F > F 0			-· IN. J	ر 	D	45391	O No	VEMBER	-6,2006
	P		29b. Signature and title of certifier 30 Name and address of person who co	propheted cause of death (Item	m 23a) (Type,	Atwood	d Road	#200,1	Bel Ain,	mDZ1014
7.	St Regist	ate	31. Date filed (Month, Day, Year)	32. Roskar's Sign	Je Je	back)				

Please Type or Print in Black Indelible Ink

enneth W. Card		State of Maryland / Department of Certificate of		Hygiene	2006 05100
Physicia		Registrar 1. Decedent's Name (First, Middle, Last)	Dealli	2. Date of Deat	eg. No 2005 35 9 5
Medical Exami	all II			Month November	Day Year
			b. City, Town, or Location of Dea		4c. County of Death
		Washington County Hospital	Hagerstown		Washington
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24H Months Days Hours M	_	th(MM/DD/YYYY) 9. Birthplace (State or Foreign
Director	ĺ	197-48-3203 1 ₁ X _M 2 _F 48 Yrs.	World Days Flours W	0ctober	28, 1958 Country Pennsylvania
ž.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	nn .	·	10d Inside City Limits
00 at		Pennsylvania Northampton Upper Mt. Beth			1 Yes 2 X No
Maryland 28a-f show any <u>dat once,</u>	ţċ	10e. Street and Number	10f. Zip Code	110	Og. Citizen of What Country?
tth the Maryland 23a or 28a-f sho notified at once.	Director	49 Shawnee Drive	18343		USA
with the is 23a enoti			Decedent of Hispanic Origin? (Specify Yes or No-	
leath '	unera	1 Never Married 2 X Married Armed Forces? If Ye 1 X Yes 2 No	es, specify Cuban, Mexican, Puer	to Rican, etc.)	White, etc.
after d	by F		Yes 2 No specify:		Specify: White
hours		during mo	's Usual Occupation (Give kind o ost of working life. DO NOT use re		16b. Kind of Business/Industry
36 in 72 han "	blet	Elementary/Secondary (0-12) College (1-4 or 5+)	nce Supervisor	·	Maintenance
with giene glene glene glene	Completed	17. Father's Name (First, Middle, Last)	·	ne (First, Middle, N	Maiden Surname)
21215-0036 Uld be filed within 72 hours after death with the Maryland Mental Hygiene marked other than "natural", or items 23a or 28a-f she e event, the Medical Examiner must be notified at once	Be C	Robert J. Card Sr.	June B		
21; ould b if Men		19a. Informant's Name/Relationship (Type, Print)	Address (Street and Number of	r Rural Route Num	nber, City or Town, State, Zip Code)
MD nd 2 shc alth and m 27 is	- 1				wp. Pennsylvania 18343
		20a. Method of Disposition 1 VBurial 2 Cremation 3 Removal from State 20b. Place of Disposic crematory or oth	tion (Name of cemetery, er place)	Date	20c. Location - City or Town, State
Page Page nent o		4 Donation 5 Other Specify: St. Vincent	de Paul Cem. 11,	/10/06	Portland Pennsylvania
Baltimore, permit Pages I at Department of Her Important: If ite		21. Signature of Funeral Service Licensee 22. N	ame and Address of Facility nard J. Ruck, INc.		
	-	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the	5 Harford Road Ba	ltimore Man	ryland 21214
Physician /Medical		failure. List only one cause on each line.			est, shock, or heart Approximate Interval Between Onset and Death
≒xaminer	- 1	Immediate Cause (Final disease or condition resulting in death) a. Hypertensive atherosclero	otic cardiovascular	disease	Dealli
		Sequentially list conditions, b			
	ner	if any, leading to immediate Due to (or as a consequence of):			
,	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
50, te be executed ysician and burial - transit		d.			
be exection a sician a unial -	edical	MENDED #23a_PTT_27_perME.	g861, 11/30/06 TT		
760, icate be physic the bur	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d Date of delivery
, P.O. Box 6876 res that the death certificate signed by the attending phy be detached for use as the be	Physician/M	past 12 months?	al death 3 Ectopic preginer (Specify)	nancy	Month Day Year
30x death	ysic	1 Yes 2 No 9 Unknown 9 Unknown	er (Specify)		
P.O. Its that the gned by the detached		Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.	23e. Did to	bacco use contribute to the cause of death?
ision of Vital Records, P.O. Box 6876 Attending Physician: The law requires that the death certificate riceath. rector: After this certificate has been signed by the attending phy by the funeral director, page 2 should be detached for use as the library.	d by	Reflex sympathetic dystrophy with narcotic u	se	1 Yes	2 No 3 Probably 4 Unknown
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	Completed			24a. Was a autop	
Recol The law cate has	i i				med? death?
Vital Rec hysician: The this certificate I director, page	Be	25. Was case referred to medical	26.Place of Death (Chec		
Vita hysicia this ca I direc	O.	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 PER/Outpatient	3 DOA Other Nurs	sing Home 5	Residence 6 Other
Ing Ph After I funeral	.:.	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Ir		28d. Describe h	now injury occurred
Sion trend death. ctor: y the t	atic	1 X Natural 5 Pending 2 Accident Investigation	1 Yes 2 No		
lor A after Direct	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, stree	t, factory, office building, etc.	28f. Location (S or Town, S	Street and Number or Rural Route Number, City tate)
Daspita, hours ineral	Cer				
he Ho in 24 he Fu pletely	ical	(Check only one) Certifying Physician: To the best of my knowledge, death occur one) Medical Examiner: On the basis of examination and/or investigation.			
Division To the Hospital or Attendin within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)
	-	1////	O.C.M.E.		November 7, 2006
		30. Name and address of person who completed cause of death (Item 23a)			
) b		/	Penn Street, Baltimore,	MD 21201	
S	tate	31. Date Net) Non(), Day, Net () () 32. Registrar's Signature			
Regis		A-Second Second			

			State of Maryl		artment of Heal ctificate of Dea			•	0.5	
1		m	Registrar 1. Decedent's Name (First, Middle, Last)		illicate of Dec	alli	2. Date of Dea	ath	3. Time of Death	4
	Physici /Medic		MARGARET DENNIS				NOV.	04 ^{Day} 200	06 1:00P	M
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Loca			4c. Coun	ty of Death	
			FUTURECARE - SANDTOWN / WINC 5. Social Security Number 6. Sex 7. Age (In	HESTER yrs. last birthday)	BALTIMO If Under 1 Year if U	ORE CIT	8. Date of Birt	h	N/A 9. Birthplace (State or Forei	eian
	Funeral Director			79 Yrs.	Months Days Ho	ours Min.	01/31	'/ ^{Yea} r)27	MARYLAND	igi.
	pue M		Usual Residence of Decedent 10a. State 10b. County 10c	c. City, Town or Loc	cation				10d. Inside City Limit	nite
	Maryla f sho ied at	tor	MD N/A		LTIMORE C	CITY			XIXYes 2□N	
	th the	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of	f What Country?	
	ath wil		1000 N. GILMORE STREET		21217			USA		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at ODCe.	by Funeral	11. Marital Status 1		Vas Decedent of Hispan f Yes, specify Cuban, Mo I □ Yes XX No <i>Sp</i>	nic Origin? (Spe exican, Puerto I pecify:	cify Yes or No- Rican, etc.)	Bla	ace - American Indian, ack, White, etc.	
5-0036	72 hor	eted	15. Decedent's Education (Specify only highest grade completed)	(Give	lent's Usual Occupation kind of work done during	a most of working	na	16b. Kind of I	Business/Industry	
2121	within ene. than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life. L	OO NOT use retired) MEMAKER	,		DOMI	ESTIC	
d 2	Hygie other ent, th	Be Co	6TH 17. Father's Name (First, Middle, Last)			Mother's Name	(First, Middle,			_
ylan	ould be Menta arked atic ev	To B	JOHN DENNIS				E MAE			
Maryland	12 sho h and 7 Is m traum		19a. Informant's Name/Relationship (Type. Print) VERNON SPRIGGS / SON	1	g Address (Street and N HERBERT					
ē,	Healt tem 2	- (0b. Place of Dispos	sition (Name of		ate		- City or Town, State	—
Ē	Pages net of nt: If I		XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		natory or other place) MEM. PARK	11/10	0/06	BALTI	MORE CO., MD	i
Baltimore,	permit. Departn Importa any Inju		21. Signature of Fundial Service Licensee	1	Name and Address of LIBER	110			AL HOME 21207 BALTIMORE, MI	
	4		23a. Par A Enter the dise se, or complications that caused the canada, or he in failure. List only one cause on each line.	death. Do not ente	er the mode of dying, su				Approximate Interval Between Onset and Death	
1	Physician /Medical		Immedia (Ca ye (Final disease); a dition resulting in death) a.	Coron	ary 18th	vry ,	Dise	ase	Onset and Death	- 111
	Examiner		Due to (or as a con	isequence or):	•	O				
	# d	iner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	nse uence of):						
_	The law requires that the death certificate be executed ate has been signed by the attending physician and agge 2 should be detached for use as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	nsequence of):						
68760,	e be ex sician e buria	SalE	d							
	rtificate ng phy as the	Medical	15.55111.5							
Box	res that the death certil signed by the attending be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf properties that the past 12 months?	Fetal death 3□	Ectopic pregnancy				ate of delivery Month Day Year	Į.
P.O.	the dev	ysic	1 ☐ Yes 2 No 4 ☐ Pregnant at time 9 ☐ Unknown	of death 5∟	Other (specify)				bay roat	
ر. ح	s that I	by Ph	Part II. Other significant conditions contributing to death but not	•		Part I.	23e. Did to	bacco use cor	ntribute to the cause of death?	
ğ	w requires been sig should by		Stroke Acuti R	espira	tory fac	luri	101	′es 2 No	3 ☐ Probably 4 Munknow	٧n
ecc	has be	Completed	nlymonia				24a. Was autop	sy	. Were autopsy findings availab prior to completion of cause of	ole of
a E	yslclan: The is certificate hadirector, page		,					rmed? 2 XI -No	death? 1 ☐ Yes 2 M No	
Ę	siciar s certifi	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpatient	Others	Place of Death			Mh (0	
0 (g Phy ter this neral d	n: To	27. Manner of Death 28a. Date of Injury	28b. Time of	28c. Injury at Work?	Nursing Hon	28d. Describe h			—
sior	tendlr. eath. tor: Af the fur	catio	2 Accident investigation		M 1 ☐ Yes	2 □ No				
Division or Vital Records,	or At after d Direct	Certification:	4 Homicide determined 28e. Place of injury - 4 building, etc. (Sp		eet, factory, office	2	28f. Location (S City or Tow		nber or Rural Route Number,	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica campletely filled in by the funeral director.	Medical Co	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my 2 Medical Examiner: On the basis of examiner and manner stated.	/ knowledge, death mination and/or inv	o occurred at the time, day restigation, in my opinion	ate and place, a n, death occurre	and due to the ed at the time,	cause(s) and n	nanner as stated.	
	To the within To the Comple	Me	29h Signature and title of certifier		29c. License num		:	29d. Date sign	ed (Month, Day, Year)	\neg
)			PHYSICI	AN	D 5	7543		11-6-	-06	
	2		30. Name and address of person who completed cause of death P . $SANDHU$, MD , 194	(Item 23a) (Type, I	Print)	CC	RAITI.	moot	ΛΛ Λ .9 . 0 . 2	
	, Sta	ite	31. Date filed (Month, Day, Year) 32. Pr gistrar's S	Signature		* / /	-14-111	-) UK L,	MD21223	
	Registr	25	NOV 0 8 2006	. 1% CA	2242L					

06-08051 2 Michael Lamont Day

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		1. For State Registrar		ertificate of	Death	_	eg No 200	25.10
Physici Medical Exami		1. Decedent's Name (First, Middle,Las				2. Date of Dea Month October 2		3 Time of Death 7
- admin		MICHAEL LAMONT 4a Facility Name (if not institution, given	DAY e street and number)	44	. City, Town, or Location of		4c County of Death	00001113
)		Mercy Hospital			Baltimore			
Funeral Director		5. Social Security Number 6. S		last birthday)	If Under 1 Year If Under Months Days Hours	Min	th (MM/DD/YYYY) 9 Birt Cou	
Director		Usual Residence of Decedent	M 2 F	51 Yrs.		JAN.	22,1955 WAS	SH., DC
any		10a. State 10b. County		ty, Town or Locatio	n			10d Inside City Limits
Maryland 28a-f show any d at once.	ь	Md	I BA	ALTIMORE				1 Yes 2 No
Manyl r 28a-l	Director	10e. Street and Number 1010 ST. PAUL S	ST.		10f Zip Code 21202	1	Og Citizen of What Cour UNITED ST	TES
death with the Maryland or items 23a or 28a-f sho must be notified at once.	alD	11. Marital Status	12. Was Decedent Ever in	IIS 13 Was	Decedent of Hispanic Origin	2 / Specify Ves or No	- 14. Race - Americ	can Indian Black
death with the ritems 23a	Funeral	1 Never Married 2 X Married		If Yes	s, specify Cuban, Mexican, F		White, etc.	
after cral", o	by F		If Yes, Give Year or Dates.	1 1	es 2 X No specify:		Specify BLA	
hours		15 Decedent's Education (Specify o	College (1-4 or 5+)		Usual Occupation (Give kir that of working life, DO NOT us		16b. Kind of Business/Ir	
336 thin 72 than than	Completed	Elementary/Secondary (0-12) 12th	Genege (1 4 di ev)		COOK		RESTAURA	VΓ
1215-0036 Id be filed within 72 hours afte fental Hygiene. narked other than "natural". event, the Medical Examine		17. Father's Name (First, Middle, Last			1	Name (First, Middle, M	•	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	To Be	RICHARD DAY 19a. Informant's Name/Relationship (1	vpe Print)	I 19b Mailing A	Address (Street and Numb	MIE JACKSOI		Zin Codo)
		JOANN CRUTHFIELI	**		9th St., NW V			Zip Code)
ore, ML ss I and 2 sl of Health ar If item 27		20a Method of Disposition 1 Burial 2 Cremation 3	20k		on (Name of cemetery,	Date	20c. Location - City or	
Baltimore, permit Pages I an Department of Hee important: If ite		4 Donation 5 Other Specify	(CHESAPEAK	E CREMATORY	11-6-06	BELTSVILL	E, MD
Baltimo permit Page Department of Important: injury or off		21. Jun ature of Funeral Service Licen	see la la	22. ING	me and Address of Facility ITOL MORTUARY			1,770,700,771
Physician	-	23a. Part I. Enter the disease, or comp failure. List only one cause on ea	lications that Jaused the dea	37				Approximate Interval
/Medical	1		ach line. Drowning	/				Between Onset and Death
Examiner		Pr 102 2 1 1 11 2	Due to (or as a consequence	of):				
in many part and	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence	e of).				
	Examine	cause. Enter Underlying Cause c. (Disease or injury that initiated c.	Due to (or as a consequence					
uted nd ransit		events resulting in death) Last	Due to (or as a consequence	+ OT).				
Division of Vital Records, P.O. Box 68760, To the Hospital or attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	n/Medical	UNPENDED	AMENDED					
Box 68760, e death certificate be the attending physic ed for use as the bur	/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c If yes, outcome of pre		death 3 Ectopic p		23d. Date of delivery	
Sox 687 leath certifit e attending	icial	past 12 months?	4 Pregnant at time of	doath	(Specify)	regnancy	Month D	ay Year
. Bo he dear y the at hed for	Physicia	1 Yes 2 No 9 Unknown	9 Unknown	to a section of the section of		Dog Bidge		
P.O. s that the	ρ	Part II. Other significant conditions	contributing to death but not	t resulting in the uni	deriying cause given in Part		bacco use contribute to the 2 No 3 Proba	
ords, a require s been signature s been signature bround b	Completed					24a Was a		opsy findings available
e law re has t	g					autop	med? death?	empletion of cause of
Vital Rec ysician: The his certificate director, page		25 Was case referred to medical			26 Place of Death (C	1 Yes 2 heck only one)	2 No 1 Yes	2 No
Vita hysicia this ce	To Be	examiner? 1 Yes 2 No	lospital 1 Inpatient 2	✓ ER/Outpatient	Other Other	Nursing Home 5	Residence 6 Other	
Division of Vital Records, P.O. tal or attending Physician: The law requires that it is after death. al Director: After this certificate has been signed by led in by the timeral director, page 2 should be detact	ü	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury FOUND: Day, Year)	28b Time of Inju		M/itnessed in	now injury occurred ump into harbor	
ivisior I or Attend after death Director:	cati	2 Accident Investigati	Oct 26, 2006	0742 hrs	1 Yes 2 ✓ N factory, office building, etc.		treet and Number or Run	al Pouta Number City
Div ital or ral Dir Iled in	Certification:	3 Suicide 6 Could not determined	be	mone, ram, street,	ractory, office panaling, etc.	or Town, St		
D 24 hours Funeral etely fille		29a Certifier 1 Certifying Physic	an: To the best of my knowle			e, and due to the cause	e(s) and manner as starte	d
To the within To the comple	Medical		On the basis of examination and manner stated	and/or investigatio		rred at the time, date a		
~	Σ	29b. Signature and title of certifier	a 0000		29c. License number O.C.M.E.		29d. Date signed (Monitorial October 27, 2006)	h, Day, Year)
3		30 Name and address of person who	completed cause of death //to	em 23a)	U.O.IVI.E.		3010DE1 27, 2000	
			nt Medical Examiner		reet, Baltimore, MD 2	1201		
	ate	31. Date filed (Month, Day, Year)	32 Registrar's Signa	ature Aces	E)			
Regis	trar	NOV 0 8 200	b Lidgerson A	2. Maria				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Maryland / Department of Health and M	Mental Hy	giene	
		•	- State Registrar Certificate of Death	ı	Reg. No.2 0 0 5	35106
	m		Decedent's Name (First, Middle, Last)	2. Date of De		3. Time of Death
	Physici		Elva Elizabeth Dukes	Novemb	er 2, 2006	8:26 Å
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Deat	
			Upper Chesapeake Medical Center Bel Air		Harford	ı
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Bird	h 9 Rin	hplace (State or Foreign
	Director		212-22-3046 1 Months Days Hours Min.	Sep. 21		untry) Vland
	ס		Usual Residence of Decedent	vep. 21	, 1520 1141	утана
	ylan		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	the Marylar 28a-f ehow	ğ	Maryland Harford Joppa			1 ☐ Yes 2 🕵 No
	ith the	irec	10e. Street and Number 10f. Zip Code		10g. Citizen of What Co	untry?
	th wit	ie D	2331 Orsburn Lane 21085		USA	
	72 hours after death with the Maryland "natural", or items 23e or 28a-f ehow dical Examiner must be notified at	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No		
≥ ∞	after dea or items	2	1 Never Married 2 Married 1 Yes 2 XNo	o nican, ecc.)	Black, Whit	9, 0 (C.
उड	rail,	þ	3 Widowed 4 □ Divorced If Yes, Give Year or Dates:		Specify: Wir	ite
0.0	within 72 hours ane. than "natural", he Medical Exa	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of work	kina	16b. Kind of Business/	Industry
25		pid	Elementary/Secondary (0-12) College (1-4or 5+)	g		
40	led will	ě	12 Homemaker		Own Home	
	be file tal Hy d oth	Be (17. Father's Name (First, Middle, Last) 18. Mother's Name	ne (First, Middle,	Maiden Sumame)	
	ould b Menta	To I	Ernest Cooley Weaver Mary Eli	izabeth	Flood	
08	2 should be filed within 72 hours and Mental Hygiene. Is marked other than "natural; reumatic event, the Medical Exa		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rut	ral Route Numbe	er, City or Town, State, 2	(ip Code)
	aith a		Lesa M. McCaffery/Granddaughter 124 Crescent Drive,	William	sburg, Virg	inia 23188
Of ore,	ges 1 and 2 should be filed withir it of Heaith and Mental Hygiene. If itam 27 is marked other than or other treumatic event, Ita M.		comptent crematons or other place)	Date	20c. Location - City or	Town, State
-> <u>P</u>	permit. Pages. Department of H Important: If its eny injury or of		1x Burial 2 Cremation 3 Hemoval from State	-9-06	Perryville,	Mary I and
<i>co</i> <u>=</u>	artm ortar injui		De. Taring aprocepting			raryrand
Ba	permi Depa Impo eny i		McComas Funeral Ho			7 01 000
	_		23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac	or respiratory a	don, Maryla	nd 21009 Approximate
			shock, or heart failure. List only one dause on each line.			Interval Between Onset and Death
	Physician		disease or condition resulting in death) a. Endometrial (ancer			Unknown
	/Medical Examiner		Due to (or as a consequence of):			
		_	Sequentially list conditions, if any, leading to immediate b. Abdominal Hysterectom; Due to (or as a consequence of):	/		SUMOUN
_	D li ti	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury	/		
	and tran	Саш	that initiated events c	<u> </u>		
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	ficate be executed physician and sthe burial-transit	<u> </u>	resulting in death) Last Due to (or as a consequence of):			
0%	cate be physici	dicai	d			
0,0	certific nding p use as	Me	IF FEMALE:			
760	ith ce itend or use	Physician/Me	23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of del Month	ivery Day Year
(C).	e des he al	Sici	1 Tyes 2 Tho		WORL	Day 19ai
Õ.	et the	훈	9 Unknown	1		
\otimes_{-s}	requires thet the death certifi een signed by the attending hould be detached for use at	þ	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.		obacco use contribute to	
SE	w requir been si should			10,	res 2. Mo 3 ☐ Pr	obably 4 Unknown
50	≥ <u>¬</u> ¬¬¬¬	Completed		24a. Was		topsy findings available
7,8	The law rate has be	E			rmed2 death?	2 □ No
실률	ician: Th certificate rector, pag	0	25. Was case referred to medical 26. Place of Deal			2[] 140
\ <u>\</u> \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	Physician: this certific ral director.	0	examiner?		dence 6 ☐Other (Spe	2.6.1
TTO	ding Physician: The lar h. Atter this certificate has funeral director, page 2	\vdash	27. Manper of Death 28a. Date of Injury 28b. Time of 28c. Injury at		now injury occurred	ny)
المرسا	ding F th. After funer	tion	1 VZNatural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No			
<u>⊘.is</u>	death death ctor: /	fica	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office	28f. Location (S	Street and Number or Ru	ral Route Number.
96	after Dire	Certification:	4 ☐ Homicide building, etc. (Specify)	City or Tov		
Juk 1	hours a uneral I		29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,	and due to the	cauco(c) and manner as	ctated
5	24 h Fur stely	edicai	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	rred at the time,	date and place, and due	to the cause(s)
-	To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mont	h, Day, Year)
	F ≱F 8		Men Kra 1 2 July 11 1 141,220		11/0/2	/
			1 - agran for the 1 10308		11/2/0	9
	10		30. Name and addr of person who completed cause of death I tem 23a) (Type, Print)		301 Bel A	10 MO 0 10 11
100	SHIP		31. Date filed (Month, Day, Year) 32. Registrar's Signature	>419C	JUI 1361 A	1,1110,404
	Sta Registi		NOV 0 8 2006 Marie & Coole			

Designation price Marke Just Marke Just Marke Just Marke Just Marke Just Marke Just Marke Just Marke Just Marke Just Marke Just Marke Just Marke Just Marke Just Marke Just Just Just Just Just Just Just Just				1 _ State	f Maryland / Department of Health and Me Certificate of Death		2000	35197
SENDING CONTROL OF THE CONTROL OF TH			п	Registrer 1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
## Facilities of Proceedings of Security Formation 15 Security Formation 1				Walter Levoy D	ikes			1250 M
Second Second Name of Second Name							4c. County of Death	
The first factors of the control of							0.00	
Substitution 100 Inside City Limits 100	ı			A . A . I . / () 15/4 005	Months Days Hours Min	Month, Day, Yo	ar) Q Cou	place (State or Foreign
The state of the s		p				2 1 1-3		MOHIO
The state of the s		anylar show	Ŀ	10a. State 10b. County	D 11:			
The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking, 1p Cook		the M	ecto	100 Street and Number		10-	022	
The state of the s		with Ba or	Dir	1040 E . 3 32D St.		10g.	Citizen of What Coul	ntry?
The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking, 1p Cook		death ms 2:	nera	11. Marital Status 12. Was Dec	odent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spec	cify Yes or No-	14. Race - Americ	can Indian,
The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking, 1p Cook	9	or Ita	Fu	1 Never Married 2 Married 1 7	2 No	lican, etc.)	01	etc.
The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking, 1p Cook	8	hours ural',	d b	3 Widowed 4 Divorced Year or D	ates:		DI	acc
The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking, 1p Cook	전	in 72 "net	olete	(Specify only highest grade completed)	(Give kind of work done during most of working	g 16b.	Kind of Business/In	dustry
The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking, 1p Cook	212	d with giene. ir thar	шо	Elementan/Secondary(0-12) College (-40r5+)		ah Ch	LINAMN
The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking) The Mailing Address (Sheet and Navabar or Rural Route Number, City or Town, State, 2p Cooking, 1p Cook	ng	al Hyg	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maid	en Sumame)	7
Comparing Security Comparing Compa	<u>y</u> a	ould t Ment Markac	٥	Walter Dules SR	Stell	la Gri	ce)	
Comparing Security Comparing Compa	Mar	12 sh h and 7 is m traum	-	19ā. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural	A-4 105	y or Town, State, Zip	Code)
Comparing Security Comparing Compa		fand Healt tam 2	-	20a. Method of Disposition	20b Place of Disposition (Name of Da	F	Location - City or To	0 2 1 2 1 5 own. State
Provision (Modelcal Exeminate Cause (Final Exeminate Cause) (Final Exeminate C	MO	Pages ent of nt: If i			State A	14/00 1	1 man A	ILL MI
23a. Phil. Either the disease, or complications into cause the death. Do not enter the mode of ging, such as cardiac or respiratory arest. Immediate Cause (Finite) List only one continue to continue the continue to the	<u>≡</u>	mit. Partm partm sortai / injui			22 Name and A responsion	in Francisco	0 10 5	of ires
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. The part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II.	Δ	e e la la la la la la la la la la la la la		トろんしつけつ	mo1363 4905 COLL 70.	Ralto	MD 217	717 -
Part Part				23a. Part 1. Enter the disease, or complications that a shock, or heart failure. List only one cause on a	aused the death. Do not enter the mode of dying, such as cardiac or ach line.	respiratory arrest,		Interval Between
Sequentially list conditions contributing to death but not resulting in the underlying cause given in Part I. Per P				disease or condition	itine Ischemic stroke			
Due to (or as a consequence of): State				bue to	or as a consequence of):			
Section Sect			e	if any leading to immediate Due to	or as a consequence of):			
Section Sect		ansit	mi	Cause (Disease or injury				
We was decedent pregnant in the past 1/2 months? FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal doath 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 23d. Date of delivery Month Day Year	o,	e exec ian an urial-tr		annulation in planta la la sa	or as a consequence of):			
We was decedent pregnant in the past 1/2 months? FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal doath 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 23d. Date of delivery Month Day Year	876	cate by	dica	d				
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 1 Natural 2 No 28a. Date of Injury 28b. Time of Injury 3 Suicide 4 Homicide 28b. Place of Death (Check only one) 27. Manner of Death 1 Natural 2 No 28b. Time of Injury 3 Suicide 4 Homicide 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Location (Street and Number or Rural Route Number, building, etc. (Specify)) 28d. Place of Death 1 Nursing Home 5 Residence 6 Other (Specify) 27d. Manner of Death 1 Natural 2 Nork? 1 Yes 2 No 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Location (Street and Number or Rural Route Number, building, etc. (Specify) 28d. Describe how injury occurred 28d. D	9 X	ding p	/Me		come of pregnancy			
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 1 Natural 2 No 28a. Date of Injury 28b. Time of Injury 3 Suicide 4 Homicide 28b. Place of Death (Check only one) 27. Manner of Death 1 Natural 2 No 28b. Time of Injury 3 Suicide 4 Homicide 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Location (Street and Number or Rural Route Number, building, etc. (Specify)) 28d. Place of Death 1 Nursing Home 5 Residence 6 Other (Specify) 27d. Manner of Death 1 Natural 2 Nork? 1 Yes 2 No 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Location (Street and Number or Rural Route Number, building, etc. (Specify) 28d. Describe how injury occurred 28d. D	Bo	atten atten i for u	clan	in the past 12 months?	irth 2 Fetal death 3 Ectopic pregnancy			1
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 1 Natural 2 No 28a. Date of Injury 28b. Time of Injury 3 Suicide 4 Homicide 28b. Place of Death (Check only one) 27. Manner of Death 1 Natural 2 No 28b. Time of Injury 3 Suicide 4 Homicide 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Location (Street and Number or Rural Route Number, building, etc. (Specify)) 28d. Place of Death 1 Nursing Home 5 Residence 6 Other (Specify) 27d. Manner of Death 1 Natural 2 Nork? 1 Yes 2 No 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Location (Street and Number or Rural Route Number, building, etc. (Specify) 28d. Describe how injury occurred 28d. D	o.	t the c by the achec	hysi	THE ZHOO				
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 1 Natural 2 No 28a. Date of Injury 28b. Time of Injury 3 Suicide 4 Homicide 28b. Place of Death (Check only one) 27. Manner of Death 1 Natural 2 No 28b. Time of Injury 3 Suicide 4 Homicide 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Location (Street and Number or Rural Route Number, building, etc. (Specify)) 28d. Place of Death 1 Nursing Home 5 Residence 6 Other (Specify) 27d. Manner of Death 1 Natural 2 Nork? 1 Yes 2 No 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Location (Street and Number or Rural Route Number, building, etc. (Specify) 28d. Describe how injury occurred 28d. D		s tha	oy P	Part II. Other significant conditions contributing to de	ath but not resulting in the underlying cause given in Part I.	23e. Did tobacci	o use contribute to th	ne cause of death?
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 1 Natural 2 No 28a. Date of Injury 28b. Time of Injury 3 Suicide 4 Homicide 28b. Place of Death (Check only one) 27. Manner of Death 1 Natural 2 No 28b. Time of Injury 3 Suicide 4 Homicide 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Location (Street and Number or Rural Route Number, building, etc. (Specify)) 28d. Place of Death 1 Nursing Home 5 Residence 6 Other (Specify) 27d. Manner of Death 1 Natural 2 Nork? 1 Yes 2 No 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Location (Street and Number or Rural Route Number, building, etc. (Specify) 28d. Describe how injury occurred 28d. D	ord	equire sen sig				1 Tes	2 No 3 Prob	ably 4 Unknown
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 1 Natural 2 Accident 1 Natural 2 Accident 1 Natural 2 Accident 2 Accident 3 Suicide 4 Homicide 2 Bellow of Death (Check only one) 28a. Date of Injury 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 2 Accident 1 Natural 2 Accident 1 Natural 2 Accident 1 Natural 2 Accident 1 Natural 2 Accident 1 Natural 2 Accident 1 Natural 2 Accident 1 Natural 2 Accident 1 Natural 2 Accident 1 Natural 2 Accident 1 Natural 2 Nort? 1 Yes 2 No 2 No 2 Norter 2 No 2 Norter 3 Suicide 4 Homicide 2 Suicide 4 Homicide 2 Suicide 4 Homicide 2 Suicide 4 Homicide 2 Suicide 3 Suicide 4 Homicide 2 Suicide 4 Homicide 2 Suicide 4 Homicide 2 Suicide 3 Suicide 4 Homicide 2 Suicide 4 Homicide 2 Suicide 3 Suicide 4 Homicide 2 Suicide 4 Homicide 2 Suicide 3 Suicide 4 Homicide 2 Suicide 3 Suicide 4 Homicide 2 Suicide 3 Suicide 4 Homicide 3 Suicide 4 Homicide 2 Suicide 4 Homicide 2 Suicide 3 Suicide 4 Homicide 2 Suicide 3 Suicide 4 Homicide 2 Suicide 3 Suicide 4 Homicide 2 Suicide 3 Suicide 4 Homicide 2 Suicide 3 Suicide 4 Homicide 2 Suicide 3 Suicide 4 Homicide 2 Suicide 3 Suicide 4 Homicide 2 Suicide 3 Suicide 4 Homicide 2 Suicide 3 Suicide 4 Homicide 3 Suicide 4 Homicide 3 Suicide 4 Homicide 3 Suicide 4 Homicide 4 Homicide 4 Homicide 5 Suicide 5 Suicide 6 Suicide 6 Suicide 6	ec ec	law r nas be e 2 sh	nple				24b. Were auto	psy findings available impletion of cause of
27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of Injury 3 State 27. Manner of Death 1 Natural 28c. Injury at Work? 28d. Describe how injury occurred 28d. Describe		(G LT	Con			performed?	death?	
27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of Injury 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and dadress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32 Agegistrar's Signature 32 Agegistrar's Signature 33 Date filed (Month, Day, Year) 34 Agegistrar's Signature 35 Pending investigation 36 Could not be determined 28b. Date of Injury 28b. Time of Injury at Work? 31 Location (Street and Number or Rural Route Number, City or Town, State) 28d. Describe how injury occurred 31 Location (Street and Number or Rural Route Number, City or Town, State) 28d. Describe how injury occurred 38d.	<u> </u>	sician certifi rector	8	examiner?	04			-
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Name of the control of the cause (s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature	o	ਦ ± ''	-		patient 2 Litroutpatient 3 DOA 4 Nuising Home			v)
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Name of the control of the cause (s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature	<u>o</u>	nding ath. r: Afte e fun	atlo					
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Name of the control of the cause (s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature	<u>S</u>	r Atta ter de irecto	tifle	determined 288. Place	of Injury - At home, farm, street, factory, office			l Route Number,
Madahawaw MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nadia Chaudhri MD, 10 N Greene Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Degistrar's Signature		urs aft ral Di						
Madahawaw MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nadia Chaudhri MD, 10 N Greene Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Degistrar's Signature		Hosp 24 ho Funs stely fi	dica	(Check only 2 Medical Examiner: On the bi	isis of examination and/or investigation, in my opinion, death occurred	nd due to the cause d at the time, date a	(s) and manner as st nd place, and due to	ated. the cause(s)
Madahawaw MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nadia Chaudhri MD, 10 N Greene Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Degistrar's Signature		o tha o the o mple	Me	, and man		29d. D	Date signed (Month, i	Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NAMA CHAUNTY MD, 10 N - Greene Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Degistrar's Signature)	/		Na dachaire Frim	MD 17403		11/5/01/	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		h		A	e of death (Item 23a) (Type, Print)		11/2/06	
Citate		J		1 100011		altimor	e, MD 21	201
Registral NOV () 8 ZUUD Waste For Defect	1	Sta Registr		NOV 0 8 2006	agistrar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 100 PM tephen November 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SINAI MOSPITAL OF BALTIMORE Baltimore City If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5-26-1957 Rnown as, Stephen Pavid Social Security Number 6. Sex 7. Age (In yrs. last birthday) Yrs. Birthplace (State or Foreign Country) **Funeral** Hours 103-46-6285 1**X**M 2□ F Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at Bend 1 Yes 2 □ No LN Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or Khol Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ No If Yes, Give Year or Dates: permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural", or Items; any Injury or other traumatic event the Industrial 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 20 XNo 3altimore, Maryland 21215-0036 Specify: Klac þ Specify: 3 ☐ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Paner's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19a. Informant's Name/Belationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) outh Bend Grassy 20n 9uvin atien 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Doyation 5 □ Other (Specify) 5 Other (Specify) tairlawn Name and Address of State of S 21. Sign vure of Fu ler I Servie icen e MD21133 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) hemorrhage **Physician** Intracranial da /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, it as a list of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: e attending physician and dor use as the burial-transit burial-transit Examir death certificate be executed Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ₹ 2 No 3 Probably 4 donknown 1 Tes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform Division or Vital 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be 217 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred al or Attending Patter death. After Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) INAI MOSPITAL OF 32. Registrar's Signature 31. Date filed (Month, Day, Year)

Registrar

State

NOV 08

2006

			1 - For State Registrar	State of M	larylar		artmen rtificat			ınd M	ental H	ygien Rea. N	21116	35	199
	Physici	20	1. Decedent's Name (First, Middle, La	st)							2. Date of D	eath	ay Yea	3. Time	e of Death
	Physici /Medio		Dorothy J. D								Nov 2	, 20	06		40 P M
1	Examir	er	4a. Facility Name (If not institution, given Southern Mary 1:						Location of	f Death		40	c. County of De		
	Funeral		5. Social Security Number 6. S			last birthday)		into:	n if Under 2	24 Hrs.	8. Date of B	irth		Georg	
	Director				70	Yrs.	Months	Days	Hours	Min.	8. Date of B (Month, D March	ay, Year	1936 N	irthplace (Sta Country) IIss.	te or r oreign
	pu ,		Usual Residence of Decedent 10a. State 10b. County		10- 00	*							1700 1		
	haryla r ehov	ō	Maryland Prince	George's		ty, Town or Lo	cation								e City Limits
	28a-	Director	10e. Street and Number	George S	Su.	itland	10f. Zip	Code	· · · ·			10a C	itizen of What		es 2∏No XX
	3s or		6238 Maxwell Dr	rive			101. 2.0	2074	46				ited St	,	
	death	Funerai	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U	.S. 13.	Nas Dece			in? (Spe	cify Yes or N Rican, etc.)	·	14. Race - Ar	nencan Indian	
36	or ite	y Fu	1 ☐ Never Married 2 ☐ Married	1 Tes 25			i Tes, spec 1 ☐ Yes			, Puerto i	nican, etc.)		Black, W!	111	America
Ö	within 72 hours after death with the Maryland ene. then "natural", or items 23s or 28s-f ehow he Madical Examiner must be multined at	ed by	3√3Widowed 4 □ Divorced 15. Decedent's Ed	Year or Dates:				XX							
15	in 72 n "nai	Completed	(Specify only highest gra	de completed)		16a. Deced (Give		rk done d	urina most	of workir	ng	16b. F	Kind of Busines	s/Industry	
212	d with	mo:	Elementary/Secondary (0-12)	College (1-4or	5+)	Chef	-					For	odservi	66	
b	al Hy al Hy d oth	Be C	17. Father's Name (First, Middle, Last)						18. Mother	's Name	(First, Middle			LE	
Maryland 21215-0036	Ment Ment arke	J.	Edward Will								ıst Ta				
Mar	12 sh h and 7 ie m traum	6	19a. Informant's Name/Relationship (**									or Town, State		
Ġ,	1 and Healt tem 2		Darryl Dameron (20a. Method of Disposition	Son)	20b. P	1141	.3 Rho sition (Nan	odend	la Ave	, I	Jiper 1	Marl!	ocation - City	2077	2
OL	ages ent of it: If it		Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific	Removal from State	y Sr	Place of Dispo emetery, crem mith St	natory or o	ther place) Nov	,11,	2006		wards,		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "natural", or Items 23s or 28s-f show importent: If Item 27 is marked other then "natural", or Items 23s or 28s-f show ery injury or other traumatic event, the Madical Examples uset be notified at once.		21. Signature of Funeral Service) Di						Funor		ome,Inc		71.1
ä	Depa Impo eny is		11/101	al 1	7001	53 A	1exar	ndria	Ferr	y Ro	ad. Cl	linto	on, MD	20735	Jiu
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that cause one cause on each	d the deatl	h. Do not ent	er the mod	e of dying	, such as c	ardiac o	respiratory a	arrest,	,	Approxim Interval B	nate Between
	Priysician	8 1	Immediate Cause (Final disease or condition	, Acut	e Mu	10 cardi	dinh	inch	h					Onset an	
	/Medical Examiner		resulting in death)	Due to (or as	a conser	ence of):									
		5	Sequentially list conditions,	b. Oue to (or as	a cunseur	и пве оВ									
1	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Ì											
o,	an an	Exa	resulting in death) Last	Due to (or as	a consequ	uence of):									
8760,	eath certificate be executed attending physician and for use as the burial-transit	dicai		d											
	entific ding pl	Med	IF FEMALE:	20- 1										I	- 11
Вох	eath c attend for us	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth 4☐Pregnant a	2 Fetel	I death 3	Ectopic pro						23d. Date of di Month	elivery Day	Year
<u>о</u> .	the d	Physician/Med	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9☐ Unknown	it time of de	eath 5	Other (spe	эспу)						-	
ٽ. ص	Attending Physician: The law requires that the death certific rideath in death certificate has been signed by the attending pector. After this certificate has been signed by the funeral director, page 2 should be detached for use as	by PI	Part II. Other significant conditions of	ontributing to death t	out not resu	ulting in the ur	derlying ca	use give	n in Part I.		23e. Did	tobacco	use contribute	to the cause of	of death?
rds	en sig	ed	End Stage Kenul De	since He	mis di s	ilys is D	exende	int			1 🗆	Yes 2	2No 3□F	robably 4 [Unknown
ecc	has be	pie	Systemic Lupus Cos	thematosi	40						24a. Was		24b. Were a	utopsy finding	s available
<u>=</u>	The cate h	Completed										ormed?	death?		Cause of
Zita Zita	Physician: The la r this certificate has ral director, page 2	Be	25. Was case referred to medical examiner?	Hospital:		_	-	Othor	_		Check only				
ō	Phys r this ral dii	5	1 Yes 2 No 27. Man r of Death	1 ☐ Inpati 28a. Date of Inju		28b. Time of			4 🗆 Nurs		e 5 Res		6 □Other (Sp	ecify)	
<u>0</u>	nding tth. r: Afte e fune	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Da	y Year)	Injury	м	8c. Injury Work′ 1 □ Y	es 2∐No	i	00. 20001100	11044 1111/4	19 00001100		
Division of Vital Records,	r Atte	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, e	jury - At ho	ome, farm, stre	et, factory	office		2	8f. Location (Street ar	nd Number or F	Rural Route Nu	ımber,
	ital or irs aft rai Dia led in	Cer									City or To				
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai	29a. Certifier (Check only one) 1 Certifying Physics (Check only one)	vsician: To the best iner: On the basis of	of examinat	wledge death tion and/or inv	oggurned a estigation,	in my opi	data and i	crane, a	nd due to the d at the time,	date and) and marriet a d place, and du	e ttated. e to the cause	e(s)
	To the I within 2 To the I complet	Med	29b. Signature and title of perform	and manner st	ated.			License					te signed (Mon		
	F 3 F 8		* Alex	mo				100	55/2/	0		No	V 3.00		
	110	1	30. Name and address of person who d	ompleted cause of o	death (Item	23a) (Type, I	Print)					, -0	3.7	00	
	10		Richard Palmer n	J 1328 Joh	hem	arene	25 3	ink 3	SID W	askin	glun D	1 2	0032		
	Sta Registra		31. Date filed (Month, Day, Year)	32. Registi	rar's Signal	avenue	base	9			4		-		
1 %	Tree State	1	1101 0 0	- Colors	Sales All Maries	er - 8"	-								

		•	For State Registrar	State	of Marylan		artment of H tificate of I		-	giene Reg. No.)6	35200
	Physicia		Decedent's Name (First, Midd Frances	le, Last)		E11	ett		2. Date of Dea Month	Day	Year O C C	3. Time of Death 8:14 AM
	/Medic Examin		4a. Facility Name (If not institution J.H.H.	n, give street and n			Bal	Location of Death			y of Death	
	Funeral Director		5. Social Security Number 213–14–4955	6. Sex 1 ☐ M 2 ☐ XF	7. Age (In yrs. 86	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	y, Year)	Cour	place (State or Foreign ntry) Md
	land ow		Usual Residence of Decedent 10a. State 10b. County	,	10c. Cit	y, Town or Lo	cation				1	10d. Inside City Limits
	e-fsh	ctor	Md.	NA		Balti	more					1√ Yes 2 No
	h with the 23a or 28 Ist be no	al Director	10e. Street and Number 3007 Belair R	đ.			10f. Zip Code	21213		10g. Citizen of	What Cour USA	ntry?
36	be filed within 72 hours after death with the Maryland that Hyglene. ad other then "neturel", or items 23a or 28e-f show event, it is medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Ma 3 ☒ Widowed 4 □ Divorce	rried Armed F	2 ⊠ No Sive		Was Decedent of H f Yes, specify Cuba I ☐ Yes 2 ☑ No	ispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- to Rican, etc.)		ice - Americ ack, White,	
21215-0036	2 hour		15. Decede	nt's Education		16a. Dece	lent's Usual Occup	ation	atria -	16b. Kind of E		
215	- 19	Completed	(Specify only higher Elementary/Secondary (0-12)	est grade completed College	(1-4or 5+)	life.	kind of work done of NOT use retired	during most of woi d)	rking			
	filed w Hygier Sther th		12th grade 17. Father's Name (First, Middle	(ast)		Coc	k	18. Mother's Nar	me (First, Middle,	Vari		
Maryland	2 should be filed withir and Mental Hygiene. Is marked other then eumatic event, Ite M.	To Be	Nathaniel		Sha	nde		Gerti				Vells
ary	2 should and Men Is marke eumatic	-	19a. Informant's Name/Relation	ship (Type, Print)	0.10		g Address (Street			er, City or Town		
	s 1 and 2 should f Health and Men item 27 Is marke other treumatic		Harry Ellett		Son		N Howard	d St. Apt	2. 2-F,]			
Baltimore,	Pages 1 nent of H ent: If ite		20a. Method of Disposition 1. □ Burial 2 □ Cremation		n State	cemetery, crer	natory or other plac			20c. Location		
altin	_ = = =		* 4 Donation 5 ☐ Other (Kı		. Park . Name and Addre	\$\frac{11-8}{\text{ss of Facility}}\$		Randa F.H. Ea		wn, Md.
ñ	Departiment Depart		> Glady	o W	anei	D	1101 E. 1	North Ave	Balt:	imore,	Md.	21202
п			23a. Part1. Enter the disease, of shock, or heart failure. Lis	r complications that t only one cause on	caused the deat each line.	h. Do not ent	er the mode of dyin	ig, such as cardiad	or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	sepsis							24245
	Examiner			Due (c	o (or as a conseq	juence or):						
	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying	Due to	o (or as a conseq	juence of):						
4	xecute and Il-trans	Examiner	that initiated events resulting in death) Last	c	o (or as a conseq	juence of):						
68760,	cate be executed physician and the burial-transit	dlcalE		d	`							
_		0	IF FEMALE:								d d	
Вох	death certific attending p	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	outcome of pregna birth 2 ☐ Feta gnant at time of c	ıl death 3□	Ectopic pregnancy Other (specify)	,			ate of delive lonth	ery Day Year
P.O.	that the death ned by the atter detached for o	hysk	1 ☐ Yes 2 █ No 9 ☐ Unknown	9□ Unk								
	sign sign d be	by	Part II. Other significant condit	0	death but not res		nderlying cause giv	en in Part I.		1		the cause of death?
Records,	s been s been s should	Completed	Derect	TCA		ι			24a. Was		Were auto	opsy findings available ompletion of cause of
I Re		Com							autop perfo 1∐ Yes	rmed? 210 No	death?	No No
of Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medic examiner?	Hospital:		,	Oth	or	ath (Check only o			
	S S	: To	1 ☐ Yes 2 No 27. Manner of eath	28a. Date	e of Injury	ER/Outpatier 28b. Time o	IL 3 DOA	4 Nursing F	lome 5 Resid			<i>(y)</i>
ion	Attending I r death. ector: After by the funer	atior	1 Altural 5 Pend	ing (Mo tigation	onth, Day Year)	Injury		k? Yes 2□No				
Division	l or Attenuater deatl Director: I in by the	Certification;	3 Suicide 6 Could 4 Homicide deter	mined 289. Place	ce of Injury - At h Iding, etc. (Specia	ome, farm, str fy)	eet, factory, office		28f. Location (S City or Tox		ber or Rura	al Route Number,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical Co		ing Physician: To the I Examiner: On the and ma								
	To the within To the	Me	29b. Signature and title of certific				29c. Licens			29d. Date sign		
	1		mark	w No	rul	1	DS	1575	7	NOV	2.	2006
	5		30. Name and address of person	ρ . \mathcal{N}	CNGL	- NC = A	Print) + a 4	0 80	s de ca	Are	- B	2=06 =H,M9
	Sta Registi		31. Date filed (Month, Day, Yea NOV	0 8 2006	Registrar's Signa	ature //	facts					

Frances Ellett

		1 - For State Registrar	State of	Marylan				lealth a Death	and M	ental Hyg	iene	06	35201
Physici		Decedent's Name (First, Middle, Lucille Engram	Last)							2. Date of Dea Month	th Day	Yeer 2006	3. Time of Death 1242 M
/Medio		4a. Fecility Name (If not institution,	give street and numb	oer)		4b. City	Town, or	Location of	of Death	7 · · · · ·	4c. County		1010
		St. Agnes Hospital							more			n/a	
Funeral Director		5. Social Security Number 216–20–5575	5. Sex 1 ☐ M 2 X ☐ F		last birthday) 8 Yrs.	Months Months	Days	If Under : Hours	Min.	8. Date of Birth (Month, Day 04/06	/ _{Year)} /1938	9. Birthp Coun	place (State or Foreign stry) SC
D .		Usual Residence of Decedent 10a. State 10b. County		10c Cit	ty, Town or Lo	nealine						1	0d. Inside City Limits
Aaryla fehov	ō		n/a	100.01	y, rown or Ec		timore	e, Mary	land	21229		'	1X Yes 2 □ No
158 N	rect	10e. Street and Number	-,			10f. Zij	o Code			1	0g. Citizen of	Whal Cour	ntry?
h with	O E	1013 Augusta Avenue					2122	29				USA	
ING 21213-UU36 be filad within 72 hours aftar daath with the Maryland tal Hygiana. d other then "naturel", or Itema 23a or 28a-1 ehow event, the Madical Examiter must be coulded at	y Funeral Director	11. Marital Status 1 Never Married 2 Marrie	If Yes, Give	es? ██No		Was Dece		ispanic Origin, Mexican	gin? (Spe , Puerto l	cify Yes or No- Rican, etc.)		ce - Americ ck, White,	etc.
hours Fig.	ed by	3 ₩ Widowed 4 □ Divorced	Year or Date	es:	16a. Dece	dont's Hay	al Ossue	ation			16b. Kind of B	Brac	
Maryland 21215-0035 d 2 should be filad within 72 hours af th and Mental Hyglana. If is marked other then "naturel", or traumatic event, the Medical Exam	Completed	(Specify only highest Elementary/Secondary (0-12)		lor 5+)	(Give		ork done d	during most	of workii	ng	16b. Kind of B	usiness/inc	dustry
d 212 filad with Hygiana other the	E	8th	n/a			ca	terer	(self-	emplo	yed)	с	aterin	g
tal Hy	Be	17. Father's Name (First, Middle, L.						18. Mothe	r's Name	(First, Middle,		ne)	
arylan should be ind Mental in marked o umatic eve	2	Ang 19a. Informant's Name/Relationshi	gus James		10b Maili	na Addens	s (Street	and Alumba	e or Pura	Milnni Route Number	e Myers	State Zin	Cadal
C = M F			m / Daughter	:						bridge, V	•		(000)
or H		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 4 ☐ Donation 5 ☐ Other (Special Control of the Control		ate	Place of Disponentery, creation	matory or	me of other plac		.1/07/		20c. Location - Baltimor	•	
Baltimo parmit. Page Dapartment o Importent: If eny injury or		21. Signature of Funeral Service Li				2. Name a		s of Facilit	y Wy	lie Funer	al Home,	P.A.	
T 405 8 9		23a. Part1. Enter the disease, or c	yones							t; Baltim		yland	21217 Approximate
/Medical Examiner	Examiner	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	r as a consequence as a	Je/ juence of):	Int	-u ~ (ctio					Interval Between Onset and Death Z
ecords, P.O. Box 68/60, Iaw raquiras that the death cartificate be executed es been signed by the attending physician and c. should be detached for use as the buriat-transit.	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	d. 23c. If yes, outco	ome of pregna	ancy	⊒Ectopic p ⊒ Other (s						ite of delive	ery Day Year
dS, P.O. I uiras that tha da signad by the a id ba datached f	by Phys	9 AUnknown Part II. Other significant condition			sulting in the u	ınderlying	cause give	en in Part I.		23e. Did to	pacco use cont	tribute to th	ne cause of death?
COLDS W raquira: been sig should by	ed b	Chronic	- Renal	fa	6/ W1	<u>^e</u>				1 □ Y	s 2 No	3 🗌 Prob	ably 4 Unknown
Tha Tha ata h	Completed	Candial	МуораТ	47						24a. Was a autops perform	ned?	prior to cor death?	psy findings available mpletion of cause of
r VICAL Pysicien: Thysicien: The is cartificata director, pag	Be	25. Was case referred to medical examiner?	Manaitali II				1 04		of Death	Check only on	e)	-	
Physi Physi this c	2	1 Yes 2 No	Hospital: 1 X Inc		ER/Outpatier 28b. Time o			4 🗀 140		ne 5 Reside			y)
On Conding P	ţ	1 Natural 5 Pending 2 Accident investigs	(Month,	Day Year)	Injury	м .	28c. Injun Worl 1 ☐ 1	k? Yes 2 ∐1		.ou. Describe m	ow inquity occur	100	
DIVISION OF VITA To the Hospital or Attending Physicien: Within 24 hours after death. To the Funeral Director: After this cartific cumplately filled in by the funeral director.	Certification:	3 Suicide 6 Could no 4 Homicide determin	at he	f Injury - Al h j, etc. <i>(Specii</i>	ome, farm, sli fy)	reet, factor				28f. Location (SI City or Town		oer or Rura	l Route Number,
To the Hospital Within 24 hours a To the Funaral complately filled	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the b xaminer: On the bas and manne	is of examina	owledge, deat ation and/or in	h occurred ivestigation	at the time, in my of	ne, date an pinion, dea	d place, a	and due to the c and at the time, d	ause(s) and ma ate and place,	anner as st and due to	ated. the cause(s)
within To th compl	Me	29b. Signature and title of certifier	00				c. License				9d. Date signe		
196		Michael S. V	Ballo 1	M.O.			15	622	-6	A	loveme	her 2	2,2006
4		30. Name and address of person w	no completed cause	of death (Iter	n 23a) (Type,	Print)			1				2,2006
	nto-	31. Date filed (Month, Day, Year)	ALLO, M.I). 9	DO CA	TOW	AUI	E -C	196	TIMOI	RE, M	Da	3/734
Sta Regist		NOVOS		lan an a	H. L	made	P						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** October 30, 2006 Vincent D. Ferracci, Jr. 9:44 a M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 1411 W. Hillside DRive Bel Air Harford If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) May 21, 1950 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1□M 2□F Days Hours Maryland 216-54-5970 56 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. Harford Bel Air 1 ☐ Yes 2 No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21015 U.S.A. 1411 W. Hillside Drive 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 🐴 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Narried white 1 ☐ Yes 2 🖾 No Specify Specify: Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (self-employed) Elementary/Secondary (0-12) 12 years College (1-4or 5+) truck driver hauling 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Vincent D. Ferracci, Sr. Irene Damico 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Ferracci/wife 1411 W. Hillside Drive, Bel Air, Md. 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 I Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cem. 11/2/06 Baltimore, Md. 1 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Metastatic Immediate Cause (Final Colon Cancer neeus resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for se's numerousing offi Examiner Due to (or as a consequence of): Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check or one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M. D October 31, 2006 D 45390 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MYD MIN (MD.) GOZ SONTH ATWOOD ROPD #200, BELAIR, MDZIO14 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar DHMH 17 Rev 1/2001

Funeral

Director

in than "natural", or Itama 23a or 28a-f show the Medical Evantine must be notified at

1 and 2 should be filed within 72 hours after death with the Maryland

Hygiene.

and Mental

Health itam 27 i

permit. Pages to Department of Himportant: If its any injury or ot

Physician

/Medical

Examiner

as the burial-transi

esn

detached

funeral director, page 2

death.

To the Hospital o within 24 hours aft

after death filled in by the

þ

or Attanding Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

other traumatic evant,

Baltimore, Maryland 21215-0036

1. Specti

		•	1 - For State Registrar	State	of Marylar			nt of H <i>te of L</i>		and M	ental H	lygier Reg. 1	/	06	35	20	3
			Decedent's Name (First, Middle	e, Last)							2. Date of	Death		-	3. Time	of Death	
	Physicia		Patricia Tan	a Ford							Octob		^{Эау} 31. 20	7 ear 106	7:11	PN	A
	/Medic Examin		4a. Facility Name (If not institution	-	umber)		4b. City	, Town, or	Location o	f Death			4c. County			<u>-</u>	
			9027 Fieldcha	t Road				ittin					Bal	timo	re		
	Funeral Director		5. Social Security Number 214-56-8055	6. Sex 1 ☐ M 2 ∑ F	7. Age (In yrs. 55	last birthday) Yrs.	If Unde Months	Days	If Under a	24 Hrs. Min.	8. Date of (Month, June	Birth Day, Yea 21,	1951	9. Birthp Cour Marci	place (State otry) yland	e or Foreig	רון
	pu »	-	Usual Residence of Decedent 10a. State 10b. County		100 0	ity, Town or Lo	antion								Od Ippido	City Limits	
	ehov ehov	5			100.01											es 2 🕱 No	
	the M	Director	Maryland Balti 10e. Street and Number	more		N C		ıgham □ Code				100	Citizen of W	hat Caus			
	with	直	9027 Fieldcha	t Road			101. 2		1236			109.	U.S.A		щу:		
	ns 23	Funeral	11. Marital Status	12. Was De	cedent Ever in U	J.S. 13. V	Was Deci			gin? (Spe	cify Yes or Rican, etc.)	No-		-	an Indian,	_	
٥	after or Item		1 ☐ Never Married 2 Marr	ned 1 Yes	2 🔼 No	-				, Puerto I	Rican, etc.)			, White,			
	ral', c	d b	3 ☐ Widowed 4 ☐ Divorced	ff Yes, C Year or			□ Yes	2 X No	Specify:				Specify:	wnc	Le		
ה	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28e-f ehow event, the Medical Examinar must be notified at	Completed	15. Deceden (Specify only highe	t's Education st grade completed	d)	16a. Deced (Give	lent's Usi kind of w	al Occupa	ation <i>furing</i> most)	of working	ng	1	Kind of Bus				
V	within	dm	Elementary/Secondary (0-12)	College	(1-4or 5+)	life. L	Owne)				lb-Emp				
V	e filed within al Hygiene. I other than '	င္ပ	17. Father's Name (First, Middle,	Last)		1	owne		18. Mothe	r's Name	(First, Mid		g & Ta en Sumame		CO.		
<u>a</u>	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar artment of Health and Mental Hygiene. ortent: If Item 27 is marked other than "natural", or Items 23a or 28e-f ehow Injury or other traumatic event, the Medical Examiner must be notified at all.	To Be	John Frederi	-						сy	Graz			-7			
	shou ind M ind M ind M		19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailin	g Addres	s (Street a	and Numbe	r or Rura	l Route Nu	nber, Cit	y or Town, S	State, Zip	Code)		
Ž	and 2 naith a 127 is or tra		Robert K. Ford	, III (hu	isband)	9027	Fiel	dcha	t Roa	d, N	otting	gham,	, MD	2123	36		
9	of He of He f Item r oth		20a. Method of Disposition 1 Burial 2 Cremation	3 □Removal from		Place of Dispo cemetery, cren	sition (Na natory or	me of other place	Maux.	D	ate	20c.	Location - (City or To	wn, State		
altimo	permit. Pages Department of I Importent: If Ite any Injury or of		4 Donation 5 Other (S	pecity) Entom	bment Sa	icred H	eart	of J	esus	11/0	4/200	6 Ba	ltimo	re, i	Maryl	Land	
<u></u>	Depart Import Import In Inj		21. Signature of Funeral Service	Licensee									ieral				
	00 = 0		700 de								altim		MD = 2	1236			
			23a. Part1. Enter the disease, or shock, or heart failure. List	only one cause on	each line.					_		•			Approxim Interval B Onset an	Between	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_ a	metai		_ /3	rea	IT (orc	enos	na			44	cari	-
	Examiner			Due to	o (or as a consec	quence of):									V		
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. — Due to	o (or as a consec	quence of):			-								
	outed Id ansit	Examiner	Cause (Disease or injury that initiated events	S c.													
Š	e exe ien ar urial-t	EX	resulting in death) Last	Due to	o (or as a consec	quence of):											
00/0	ficate be executed physicien and is the burial-transit	dical		d							-						
0	entific ding p	Med	IF FEMALE:	220 # 1100 0										1			
2 02	death certifi e attending i id for use as	lan/	23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of pregn birth 2 Fet	al déath 3 □		pregnancy					23d. Date Mon		ory Day	Year	
5	the de	Physiclan/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unk	gnant at time of one of the contract of the co	Jean 5	Other (s	респу)				_					
ŗ	w requires that the death certifi been signed by the attending I should be detached for use as		Part II. Other significant condition	ons contributing to	death but not re	sulting in the ur	nderlying	cause give	n in Part I.		23e. D	d tobacc	o use contri	bute to th	e cause o	of death?	
Hecords	quires n sigr	d by									11	Yes	2/100	3 🗌 Prob	ably 4 (Unknow	n
000	s bee	olete									24a. W		24b. W	ere auto	psy finding	s available	ө
_	sician: The law r certificate has be lirector, page 2 sh	Completed									at pe 1 ☐ Ye	ntopsy ortormod s 2	ζ de	nor to con eath? ⊒Yes	mpletion o	t cause of	
N [2]	itan: ntifica ctor, p	Bec	25. Was case referred to medica examiner?	f					26. Place	of Death	(Check on						
> 5	Physician: this certific ral director,	To I	1 ☐ Yes 2 2 No	Hospitaf: 1	fnpatient 2	ER/Outpatien			4 🗆 1901	rsing Hon	ne 5∭2 R	esidence	6 □Othe	r (Specif	y)		
	ing P	lon:	27. Manner of Death 1 Natural 5 □ Pendir	ng (Mo	e of Injury onth, Day Year)	28b. Time of Injury		28c. Injury Work		1	8d. Descrit	e how in	jury occurre	d			
UNISION	death death stor: / the f	Icat	2 Accident investi 3 Suicide 6 Could	not be	ce of Injury - At h	lomo farm str	M I		fes 2□N		ORf Location	\Street	and Numbe	ror Russ	I Pouto M	umbar.	
≥	el or A s after il Direction by	Certification;	4 ☐ Homicide determ	buil	ding, etc. (Speci	fy)	eet, iacto	ry, onice				Town, Sta		i oi riula	I HODIO IVI	umber,	
	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical (29a. Certifier 1. Certifyir (Check only one) 2 Medical	ng Physician: To the Examiner: On the and ma	he best of my kno basis of examina inner stated.	owledge, death ation and/or inv	occurre estigatio	at the tim	e, date and pinion, deat	d place, a	and due to to	he cause ie, date a	(s) and man	ner as si	ated.	9(s)	
	To th withir To th comp	Me	29b. Signature and title of certifie	r /	1			c. License				29d. [Date signed	(Month,	Day, Year,)	
			Lans 1	n Hal	- 111	0		10 -	2039	6		No	remle	~ 3.	260	6	
1	5		30. Name and address of person	who completed ca	use of death (fte	m 23a) (Type,	Print)					1					
			Davis M Hah	2 2001	Loch	m 23a) (Type, Lower	Bh	d#1	03	Bar	to. L	00	21239	}			
	Sta Registr		31. Date filed (Month, Day, Year)	40		ature											

State of Maryland / Department of Health	and Mental Hygiene 20	06

			1 - State		State of	i Maryla				tealth and Death	Mental Hy	_		U b	35204
			Registrar 1. Decedent's Name	e (First, Middle, La	ast)		Ce	lilica	le oi	Dealli	2. Date of D	Reg. No			3. Time of Death
	Physici /Media		Robert M								Novemb	er l			0049 ам
	Examir	ner	4a. Facility Name (/					4b. Cin	_	r Location of Dea	th	40	. County		
	Funeral	-	Upper Ch 5. Social Security N				Y s. last birthday)	If Und	Bel er 1 Year	Air If Under 24 Hrs	8. Date of B	irth	Hari		lace (State or Foreign
	Director		145-36-1	202	1 ⊠ M 2□F	60	Yrs.	Months	Days	Hours Min	Feb. 4	ay, Year,	46		lace (State or Foreign try) Jersey
	p.		Usual Residence of	Decedent							, CD . 1	,			
	anyla show	5	10a. State	10b. County		10c. C	ity, Town or Lo	ocation						11	0d. Inside City Limits 11√2 Yes 2 □ No
	he M	ecto	Md . 10e. Street and Nur	Harfo	rd				oppa						
	with with the party	ă						10f. Z	ip Code	0.5		_		/hat Coun	try?
	death with the Maryland ms 23a or 28a-f show rmust be notified at	Funeral Director	115 Rave	iiswood C	12. Was Dece	dent Ever in	U.S. 13.	Was Dec	210 edent of F	dispanic Origin? (S an, Mexican, Puer	Specify Yes or N		S . A . 14. Race	- Americ	an Indian,
36	or its	þ	1 🗆 Never Marri 3 🗆 Widowed	ied 2 [2] Married 4 □ Divorced	Armed For 1 Types If Yes, Giv Year or Da	2 🗆 No e	1		ecify Cuba 2₩ No	an, Mexican, Puer Specify:	rto Rican, etc.)		Specify:	k, White, e wh	etc. ite
♂ ?	72 hours "natural",	eted	(Spec	15. Decedent's E	ducation		16a. Dece	dent's Us	uai Occup	ation	nrkina	16b. k	Cind of Bu	siness/Ind	dustry
02	be filed within 72 h tal Hygiene. d other than "natu event, the Medical	Completed	Elementary/Seco		College (1	-4or 5+)				during most of wo	nung				
72	iled w lygier ther ti		17. Father's Name	/Eight Middle Las	4		sal	Lesma	ın	10 Markada Na	/5: 60:44			ice s	ales
		Be	Robert E							Anne O	me (First, Middle	e, Maider	1 Sumam	θ)	
چ	should of Men marks matic	ပ	19a. Informant's Na				19b. Mailie	na Addres	s (Street	and Number or R		her City	or Town	State Zin	Code)
S	nd 2 state and 2 state and 2 state and 27 is read		Mary W.							d Court,					0000)
Itinore, Mary	0 0			Cremation 3 [SIALLE	Place of Dispo			1	Date			City or To	
	permit. Pag Department Important: i any injury o		4 ☐ Donation 21. Signature of Fu	5 ☐ Other (Speci	-	50	. Josep				4/2006	_		re,	
<u>— 8</u>	Dep Pen		THE	>1			3	chin	unek	ss of Facility Funeral	Home of	E Bei	l Air	, In	
			23a. Part1. Enter ti	he disease, or con	plications that ca	aused the dea	ath. Do not ent	er the mo	. Ma de of dyin	cPhail R ng, such as cardia	oad, Be.	L Ail	r, Mo	21	014 Approximate
	Physician		Immediate Cause disease or condition	(Final	one cause on ea	acrimie.			1						Interval Between Onset and Death
	/Medical		resulting in death)	-	aDue to (or as a conse	quence of):	ue	1						
	Examiner		Sequentially list co	aditions	b{	reh	mi	cu	eli	outel	el,				
	p ti	Iner	Sequentially list confidence in any, leading to in cause. Enter Unde Cause (Disease or	imediate prlying	Due to (or as a conse	quality of).			2	, ,				
	ificate be executed g physicien and as the burial-transit	Examiner	that initiated events resulting in death) I	5	C. Due to (or as a conse	cuence of):								
58760,	be exicient					51 43 4 00136	quence on,								
108	ficate phys s the	edical			_ d										
7 ×		n/Me	IF FEMALE: 23b. Was decedent	t pregnant	23c. If yes, outo	come of pregr							23d. Date	of deliver	rv
0 m	death cert e attendin id for use	hysician/M	in the past 12	months?	4∐Pregna	nth 2 ☐ Fet ant at time of]Ectopic] Other (s	pregnancy pecify)	1			Mon		Day Year
1.10	s that the de ned by the a e detached f	hys	9 ☐ Unknown		9□ Unkno	wn									
S, L	ë .5° 5	by PI	Part II. Other signif	icant conditions	4				_	en in Part I.					e cause of death?
1000 l ecords,	w requir been si should	ted	Chone	i obste	ders pe	luon	Jalen	~~~			10	Yes 2	□No	3 🗌 Proba	ably 4 Unknown
\ 	aw S b	Completed	Steep	aprece							24a. Was		24b. W	ere autop	osy findings available inpletion of cause of
2 =	T ate	Con	pul	many	higher	lun						órmed? 2 ☐Noo		eath? □ Yes :	20 No
さい	Physician: Th this certificate ral director, pag	Be	25. Was case reference examiner?		Hospital:				1.0%		ath Check only				
o to	Phys this al dii	<u>٦</u>	1 Yes 2 27. Manner of Deatl		28a. Date o		28b. Time of			4 Nursing F	dome 5 ☐ Res)
वृह	inding Phyath. r: After thi	tlon	Natural	5 Pending investigation	(Month	n, Day Year)	Injury	м	28c. Injun Worl	yat k? Yes 2 □No	28d. Describe	now inju	ry occurre	9G	
rd Rob Bilision	spital or Attandi ours after death. ieral Director: A filled in by the fu	Certification:	2 Accident 3 Suicide	6 Could not be	e 28e. Place	of Injury - At I	nome, farm, str				28f. Location	Street ar	nd Numbe	r or Rural	Route Number,
- 6	al or s afte i Dire	Fr	4 🗌 Homicide	30.011111100	buildin	ig, etc. (Spec	ify)				City or To	wn, State	e)		
100	Hos Fur ely	edical C	29a. Certifier (Check only one)	1 Certifying Pl 2 Medical Exa	nysician: To the miner: On the ba and mann	sis of examin	owledge, death ation and/or in-	occurre vestigatio	d at the tim	ne, date and place pinion, death occu	e, and due to the urred at the time,	cause(s date and) and mar d place, a	ner as sta nd due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and	title of certifier				29	c. License	e number		29d. Da	te signed	(Month, E	Day, Year)
			3	-05	7				200	2255		N,.	ve.	2,	2006
6			30. Name and addre		completed cause	of death (Ite	m 23a) (Type,	Print)		221)		-) 220 5
9			David	0 3 3	مررن				.1	Relai	1 MA	211	014		
	Sta		31. Date filed (Mon	1h, Day, Year)	32. Re	egistrar's Sign	ature	20					-		

. iouse Type of Think in Black indelible link. Eliouie All Copies Ale Eegible.	
State of Maryland / Department of Health and Mental Hygien 006	35205
Certificate of Death	

			For State Registrar	State of Maryla	-	rtificate of			ig. No.	33203
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Deat	n	3. Time of Death
	/Medic	al	VICTORIA		ELDS				25, 2006	2:13 ам
	Examin	er	4a. Facility Name (If not institution, give s CLINTON NURSING		3D		r Location of Death	n	PRINCE G	
	Funeral		5. Social Security Number 6. Sex	7. Age (In vrs	s. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		
	Director		241-32-5803	M 20 F 79	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Pay, Dec. 11,	1926	irthplace (State or Foreign Country) N.C.
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or Lo	ocation				10d. Inside City Limits
	Many I sh	tor	Md. Charles			Bryans	Road			1X Yes 2 ☐ No
	th the or 28s e.noti	irec	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	Country?
	ath wi	ral	6627 Bucknell Ro	ad			20616		United	States
	tams Itams	by Funeral Director	11. Marital Status 1 X Never Married 2 ☐ Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 MNo	U.S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Arr Black, Wh	
980	urs aff	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1□Yes 2XNo	Specify:		Specify:	Black
2	within 72 hours after death with the Maryland ena. then "natural", or Itams 23a or 28a-f show the Modical Evaminal proval be notified at	Be Completed	15. Decedent's Educ (Specify only highest grade	ation	16a. Dece	dent's Usual Occup	ation during most of wor	rkina	6b. Kind of Busines	s/Industry
121	within na. han "	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done DO NOT use retire		9	D 4 *	- 0
d 2	filed hygie	ပိ	6th 17. Father's Name (First, Middle, Last)			Binder		ne (First, Middle, M		g Company
<u>lan</u>	Jental Jental rked tic av	To B	John Henry C	arr				Ida Tyso	n	
lary	2 short and h is ma		19a. Informant's Name/Relationship (Type						City or Town, State,	
≥ (0)	f and fealth sm 27 sher tr		Vickie Fields-Byr 20a. Method of Disposition					yans Road		616
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiena. Importent: If item 27 is marked other than "natural", or Itams 23a or 28a-1 show any injury or other traumatic avent, the Madical Examinet must be notified at once.		12 Burjal 2 □ Cremation 3 □ R	emoval from State	cemetery, cre	osition (Name of matory or other place onal Mem.	Park 11		oc. Location - City o. Laurel	
慧	mit. Poartme		* 4 □ Donation 5 □ Other (Specify) 21. Sign ture Funeral Service License	A 4					tuary, In	•
Ö	Depar Impo any it		Maron	Kun-Ja	My 1	<u>425 Maryl</u>	and Ave.	, NE Wa	sh., DC	20002
			23a. Par 1. Enter the disease, r complice shock, or heart failure. List only on	ations that caused the dea	ath. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between
H	Physician		Immediate Cause (Final disease or condition resulting in death)	CEREBROVA	SUULAR	ACCIDENT				Onset and Death 1 HOUR
	/Medical Examiner		Tooling in coaliny	Due to (or as a conse COMPLETE		NTERNAL C	ΔΡΟΤΤΟ ΔΙ	RTFRY OCC	THISTON	4 YEARS
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse		TTLITE US C	rucciid ru	KILKI OGO	100101	, 12200
	ocutad nd transit	Examlner	that initiated events			HYPERTEN	SIVE CAR	DIOVASCUL	AR DISEAS	E 10 YEARS
60,	Attanding Physician: The law requires that the death certificate be executad redeth. r death. sctor: Atter this certificate has baan signed by the attending physician and by the funaral director, page 2 should be detachad for use as the burial-transit	EX	resulting in death) Last	Due to (or as a conse	equence of):					
68760,	physi s the	Physician/Medical	d							
Box	eath certii attending for use a	n/M	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fe		3e			23d. Date of de	elivery
O. B	e death he atter	sicia	in the past 12 months? 1 ☐ Yes 2 ØNo	4☐Pregnant at time of		□Ectopic pregnancy □ Other (specify)			Month	Day Year
<u>Ч</u>	that the de led by the a detachad t	Phy	9 ☐ Unknown Part II. Other significant conditions con		asulting in the u	andertuing cause an	on in Port I	23a Did toh	acco usa contributa l	to the cause of death?
ecords,	uires t signe ld be d	d by	END STAGE RENAL		-					robably 4 Munknown
S	w require baan si should I	lete						24a. Was an	24b. Were a	utopsy findings available
\mathbf{x}	The lav	Completed						autopsy perform 1 Yes 2	ed? prior to death?	completion of cause of
Viital	ysician: The is certificate hadirector, page	BeC	25. Was case referred to medical examiner?					ith (Check only one		
	Physia this o	2	1 ☐ Yes 2 🛣 No H	A STATE OF THE PARTY OF THE PAR	ER/Outpatier		4 CANDISING IT		nce 6 □Other (Spe	ecify)
Division of	iding Phy th. : After thi : funaral	tion	1 XNatural 5 Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor	yat k? Yes 2 □ No	28d. Describe hov	w injury occurred	
N S		Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str			28f. Location (Stre City or Town,	eet and Number or F	Rural Route Number,
	ital or irs afte ral Dir led in	Cert	7	bullouring, etc. (Spec				City or Town,	Sidle/	
	To the Hospital within 24 hours a Xo the Funeral I completely filled	Medical	29a. Certifier 1X Certifying Phys (Check only one) 2 ☐ Medical Exemin	icien: To the best of my kr	nowledge, deat nation and/or in	h occurred at the tin vestigation, in my o	ne, date and place, pinion, death occur	, and due to the car rred at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	ro the vithin 2 orople	Mec	29b. Signature and title of certifier	and manner stated.	4	29c. Licens	e n <i>u</i> mber	29	d. Date signed (Mon	th, Day, Year)
4			> pamel	a elpi	ela	DO	016116		Oct. 27,	2006
2	, ·		30. Name and address of person who con			Print)				
			PAMELA GUHA 913 31. Date filed (Month, Day, Year)	32. Signistrar's Sign		#/50 CL	INTON, M	D. 20735		
	Sta Registr		NOV 0 8 201	32. 309 istrar's sign	1 4	Coast!				

State of Maryland / Department of Health and Mental Hygien 2006 35206 1 - State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** LOOPM FITCH **EDWARD** JOHN Nevember 06 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Horford Havre DeGrace Citizens Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. 05-13-1922 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months **X**□M 2□F 84 16 6692 MD **Director** Usual Residence of Decedent 10d Inside City Limits 10b. County 10c. City, Town or Location 10a State or 28a-f show in then "natural", or items 23a or 28a-f aho the Medical Examinar must be notified at 1 ☐ Yes 2\X\no HARFORD **EDGEWOOD** Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21040 526 BURLINGTON CT. r death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 □ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE If Yes, Give Year or Dates:WWII Ś 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien important: If Item 27 is marked other the eny injury or other traumatic event, Item 2006. PRINTER PRINTING 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BARBARA MILLER CLARENCE FITCH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) EDGEWOOD, MD 21040 526 BURLINGTON CT., KATHLEEN SHERIDAN/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST 11-14-2006 BALTIMORE, 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee 1211 CHESACO AVE., ROSEDALE, MD 21237 Approximate Interval Between Onset and Death 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Depti ceung **Physician** disease or condition resulting in death) /Medical Preemong Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Trace Lenfellion 8 use as the burial-transit that initiated events resulting in death) Last ettending physicien and Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Deligelación 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 1 Yes 2 No To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospitaf: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Unrsing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ို 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending 1 Natural 1 TYes 2 No death. investigation 2 Accident Director: 6 Coufd not be 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🖺 Homicide within 24 hours a completely filled 1 Certifying Physician: To the best of my knowledge, Jeath occurred at the fine, data and plane, and due to the neurol(s) and manner as stated 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature, and title of certifier 11/6/46. D32609 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Kamnam Tunan In 1106 Revolution St Have De Gran M 21078 32. Registral's Signature 31. Date filed (Month Per Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35207 Reg. N& UU6 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** traerala 10:55 AM November 2004 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death of NIA Iniversity Medical Cent Ba Hmore Mary land If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 **X**F Hours Director 10a. State 10c. City Town or Location 10d. Inside City Limits r 28a-f show notified at show **Funeral Director** 1 ☐ Yes 2 No olumbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be It 21045 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use refired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, 19a, Informant's Name/Relationship (Type. lumbia, MD 21045 altimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service estown, MD 23a. Part1. Enter he disease, or complications that caused the death. Do not ente shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Due (or as a consequence of) /Medical Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last end be executed burial-transit Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death
9 □ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy Month Year Day 5 Other (specify) P.O. ed by the a 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☑No autopsy perform 1∐ Yes 200 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After it completely filled in by the funeral 27. Manner of Ceath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 1, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 Bultimore, all Zaljoli Greene

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

Year)

NOV 0 8 2006

32. Regulrar's Signature

		ı.	For State	State of Maryland	•	rtment of H			eng 006	5 35208
			Registrar 1. Decedent's Name (First, Middle, Las	1)		inoate or i	Joan	2. Date of Death	1	3. Time of Death
	Physici /Medic		STANLEY LO	vis Gillis,	5%.			OCA ~	Day 200	
	Examin		4a. Facility Name (If not institution, give	1 11	NI	() //	r Location of Death		4c. County of E	Death
			GUUD JAMANITA	no Norsing (Entr	If Under 1 Year		O. Date of Birth	10/1	Pinthalana (State on Couries
	Funeral Director		5. Social Security Number 6. S	9X 7. Age (In yrs. I. SM 2□F S	asτ οιπησαγ) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year)	Birthplace (State or Foreign Country)
	0	1	Usual Residence of Decedent				J	110111		7
	arylan show	_	10a. State 10b. County	10c. City	, Town or Loc	HARR				10d. Inside City Limits
	179 M	Director	10e. Speet and Number	A	631	10f. Zip Code		10	g. Citizen of Wha	
:	death with the Maryland me 23a or 28a-f show r must be rediffed at			ESE AUG		2121	12		551	·
	death	Funerai	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. V	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto I	cify Yes or No- Rican, etc.)		American Indian, Vhite, etc.
30	within 72 hours after death with the Marylan ene. Than "natural", or Itame 23a or 28a-f show he Modical Exacilinar mist be rediffed at	by Fu	1 ☐ Never Married 2 ☐ Married	1- Yes 2 □ No If Yes, Give		☐ Yes 2☐ No	Specify:			Place
2-0036	tural		15. Decedent's Ed	Year or Dates:		ent's Usual Occup		1	6b. Kind of Busine	ess/Industry
<u>د ا</u>	d within 72 ho piene. r than "natur ine Medical	Completed	(Specify only highest gra	de completed) College (1-4or 5+)	(Give . life. [kind of work done of NOT use retired	during most of workii d)	rg	2/a 11 60	n Vilkge
N	ygiene ygiene t, me	Con		146m	MAIN	knomce	Supervis		apts.	
Maryland	be fill	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name			
<u> </u>	should nd Men marke imatic	၉	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street	and Number or Rura			te, Zip Code)
	d d d d d d d d d d d d d d d d d d d	1	Posetta Kerr-W	11LION	800 0	- Bew	EDENE ALG	BA/7	440K, 1	Nd 2/2/2
altimore,	es 1 an of Heal fitem 2 rother		20a. Method of Disposition 1. Burial 2 ☐ Cremation 3 ☐	1 0	lace of Dispos emetery, cren	sition (Name of natory or other place		2/00	20c. Location - City	
Ĕ.	. Pages tment of tant; if it tury or o		4 □ Donation 5 □ Other (Specific	n DUI	may 1	Intry The	construct 6		MAIONIC	
Bal	permit. Pages Department of Important; If I any injury or once.		21. Signature of Fundamental Service Licer	is ee	50	Name and Addre	ss of Facility CH		- Harris. Bethree	
			23a. Part 1. Enter the disease, or com shook, or heart failure. List only	plications that caused the death	n. Do not ente	er the mode of dyin	ng, such as cardiac o	r respiratory arre	st,	Approximate Interval Between
Ж	hysician		Immediate Cause (Final disease or condition resulting in death)	a ASPIRATIO	NP	NEUHON	IA			Onset and Death 3 months
	/Medical Examiner		resulting in dealin)	Due to (or as a consequ		10 1	ari Suma	_		2 marth
		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequ	uence of):	mx n	COLUEN.	1		3//4/4/195
	cuted nd ransit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	c.						
90,	rate be executed hysicien and the burial-transit		resulting in death) Last	Due to (or as a consequ	uence of):					
98760	the the	dicai		. d						
Box	death certific e attending pl ed for use as t	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna)c			23d. Date of	delivery
m m	0 00 0	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown		Ectopic pregnancy Other (specify)	/		Month	Day Year
P.O.	res that the de signed by the a be detached f	Phy	9 ☐ Unknown Part II. Other significant conditions of		ulting in the u	nderhving cause gru	an in Part I	23a Did toh	acco use contribut	te to the cause of death?
Division of Vital Records,	Attending Physician: The law requires that the rr death: ector: After this certificete has been signed by the by the funeral director, page 2 should be detached.	Completed by	DIABETES	or in builty to abatif but for for	and at the di	idonying oddao giv	on an and a			Probably 4 Unknown
cor	w require been sign should b	lete	CORONARY ARTE	AV DISEASE	-			24a. Was ar	24b. Wer	e autopsy findings available to completion of cause of
Re	Physician: The lav this certificate has al director, page 2	шо	COROPAIC TARIE	ic risense				autops perform 1 Yes 2	led? ∣ deat	rto completion of cause of h? Yes 2□ No
ita	stan: artifice ctor. p	Bec	25. Was case referred to medical examiner?				26. Place of Death			
<u> </u>	hysic this ce al dire	၉	1 ☐ Yes 2 No		ER/Outpatien		4 Nursing Hor		nce 6 Other (Specify)
מ	ding F h. After funera	tion:	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	yat k? Yes 2 □No	28d. Describe no	w injury occurred	
Visi	Attendi r death. ector: A by the fu	ifica	2 Accident Investigation 3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At ho	me, farm, str					r Rural Route Number,
É	tai or A rs after ai Dire ed in by	Certification:	4 nomicide	building, etc. (Specify	/) 			City or Town	. State)	
	To the Hospital or Attending Ph within 24 hours after death. Xo the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exar	ysician: To the best of my kno- niner: On the basis of examina- and manner stated.	wledge, death tion and/or inv	occurred at the tire restigation, in my co	me, date and place, a ppinion, death occurr	and due to the ca ed at the time, da	use(s) and manne ite and place, and	or as stated. due to the cause(s)
	To the To the comple	Me	29b. Signature and title of certifier	12.5		29c. Licens			d. Date signed (N	
)	5		* Ofperling	ry MD		DZ	8987	1	1/02/20	ok.
)	5		30. Name and address of person who	completed cause of death (Item	RAVE	N BLVD	BALT	o, MD	21239	
	Sta		31. Date filed (Month, Day, Year) NOV 0 8 20	32 Registrar's Signa	ture	rate 1	· _ • · · · · · · · · · · · · · · · · ·			
	Regist	al	7010020	Jan Jakan Sa	PORTE	- Abaton				

State of Maryland / Department of Health and Mental Hygiene

If Under 1 Year

10f. Zip Code

Months

Days

06 Certificate of Death Reg. No.

Physician	
/Medical	
Examiner	

1. Decedent's Name (First, Middle, Last)

Marvin Eugene Gold

7. Age (In yrs. last birthday) 78 Yrs.

2. Date of Death Nov. 3, 2006 35209 3. Time of Death

11:35a

10d. Inside City Limits

1 X Yes 2 No

4a. Facility Name (If not institution, give street and number)

Bethesda Health and Rehab Center

18 M 2□ F

4b. City, Town, or Location of Death Bethesda If Under 24 Hrs.

4c. County of Death Montgomery

Year

Funeral Director

> Usual Residence of Decedent 10a. State 10b. County IN. Porter

5. Social Security Number 3 3 5 - 20 - 9 8 8 4

10c. City, Town or Location

Valparaiso

Date of Birth (Month Day Year) 9/02/1928

9. Birthplace (State or Foreign Country)
Chicago, IL.

Director Funeral

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "netural", or Items 23a or 28e-f show any injury or other treumetic event, Ite Modical Exertment must be not estimated. Be ၉

ģ Completed

10e. Street and Number 2117 Wynnewood Drive 11. Marital Status

12. Was Decedent Ever in U,S. Armed Forces? 1점Yes 2☐No 195 If Yes, Give Year or Dates: 1955 1958

46385 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Hours

1 ☐ Yes 2 X No Specify:

14. Race - American Indian, Black, White, etc. White Specify

15. Decedent's Education (Specify only highest grade completed)

College (1-4or 5+) 5 +

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

Elementary/Secondary (0-12)

Medical Doctor

Medicine

10g. Citizen of What Country?

USA

17. Father's Name (First, Middle, Last)

1 ☐ Never Married 2 Married

3 ☐ Widowed 4 ☐ Divorced

Samuel Gold

20a. Method of Disposition

18. Mother's Name (First, Middle, Maiden Surname)

Kate Shapiro

19a. Informant's Name/Relationship (Type, Print)
Sharon Fisher/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17204 Evangeline Lane Olney, Maryland 20832 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date

1 Surial 2 ☐ Cremation 3 A Removal from State 4 ☐ Donation ≥ 5 ☐ Other (Specify) 21. Signatur vuneral Service Licensee

Graceland Cemetery

11/06/06 Valparaiso, IN.

23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause on each line.

PHYTTP AGES TO ALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd. Silver Spring, Md20910

Physician /Medical Examiner

attending physician and I for use as the buriel-transit

ed by the a deteched f

page 2 should be

the funeral director,

campletely filled in by

signed by

peen

certificete has

after death. Director: After this

To the Hospital ewithin 24 hours a To the Funerel D

or Attending Physicien: The law requires thet the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Physician/Medical Examiner

þ

Be Completed

Certification: To

Medical

Baltimore, Maryland 21215-0020

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Immediate Cause (Final disease or condition resulting in death)

Congestive Cardiomyopathy

cemetery, crematory or other place)

Due to (or as a consequence of):

Urosepsis

Due to (of as a consequence of).

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

Approximate Interval Between Onset and Death

1 ☐ Yes 2 🛛 No

1 ☐ Yes 2 ☐ No

25.	Was case	referr <i>e</i> d	to medica
	1 🗌 Yes	2 X No	
27.	Manner of	Death	

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

5 Pending investigation

Hospital: 1 ☐ Inpatient Date of Injury (Month, Day Year)

and manner stated

2 ☐ ER/Outpatient 3 ☐ DOA

Injury et Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

26. Place of Death (Check only one)

6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier

29c. License number M.D. D27660

29d. Date signed (Month, Day, Year) Nov.3,2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alpana Goswami MD

11119 Rockville Pike #G-100 Rockville, Md 20852

State Registrar 31. Date filed (Month 08 gistrar's Signature

Division of Vital Records. P.O. Box 68760. SAMUEL GAGLIANO

		_	For State Registrar	State of Mary	/land / De <i>C</i>	partment of F ertificate of	lealth and M Death	R	eg. No.	35210	
	/sicia		1. Decedent's Name (First, Middle, Las Samuel J. Ga					2. Date of Dea Month	Day 200	3. Time of Death 8:30 P M	
	amine		4a. Fecility Neme (If not institution, give Stella Maris	1	4b. City, Town, or Location of Death Timonium			eath Ltimore			
Fune			Social Security Number 6. S		n yrs. last birthd 76 Yrs	ay) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	9.1	Birthplace (State or Foreign Country) Maryland	
Maryland f ehow	ied at	or	Usual Residence of Decedent 10a. State 10b. County MD Balti		Oc. City, Town o	Location OWSON				10d. Inside City Limits 1 ☐ Yes 2 X No	
after death with the Marylan or Iteme 23a or 28a-f ehow	ast the notifi	al Director	10e. Street and Number 6 Ecoway Ct. A	pt. 1D		10f. Zip Code 21	286	1	0g. Citizen of What		
urs after dea	Examiner nu	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marned 3 ☐ Widowed 4 ☑ ❤️ Vorced	12. Was Decedent Eve Armed Forces? 1∑Yes 2 ☐ No If Yes, Give Year or Dates:	or in U.S. 1	3. Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 ☒No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - A Black, W Specify:	merican Indian, thite, etc. White	
be filled within 72 hours after death with the Maryland ital Hyglene.	The Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver						16b. Kind of Business/Industry Bethlehem Steel		
2 should be filed with and Mental Hyglene. Ie marked other than	event,	Be	17. Father's Name (First, Middle, Last) Samuel J. 0	agliano S			18. Mother's Name	e (First, Middle, i			
s 1 and 2 should be filed if Health and Mental Hyg item 27 le marked othe	•umatic	၉	19a. Informant's Name/Relationship (1	Type, Print)	19b. M		and Number or Run	al Route Number	r, City or Town, State	e, Zip Code) 21224	
es 1 and 2 of Health	r other t		Michael Gagli 20a. Method of Disposition 12 Burial 2 Cremation 3		20b. Place of Di	sposition (Name of	201		20c. Location - City	·	
permit. Pages Department of h Important: If it	y Injury c		4 Donation 5 Other (Specify 21. Signature of oneral Service Licen)	Parkw	Ocemeter 22. Name and Addre Evans Fu	y 11,	2006	Parky 8800_H	ville Harford Rd. Le, MD 21234	
805	∍ a		23a. Parti. Enter the disease, or compshock, or heart failure. List only	plications that caused the		And Crem				Approximate Interval Between	
Physic /Medi			Immediate Cause (Final disease or condition resulting in death)	a. CHRONIC Due to (or as a c						Onset and Death	
Exami		-	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a c	·						
icate be executed physicien and	burial-transit	al Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a co	onsequence of):						
On		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death	3 ☐ Ectopic pregnanc: 5 ☐ Other (specify) _	y		23d. Date of Month	delivery Day Year	
quires that I	eg	<u>م</u>	Part II. Other significant conditions c	ontributing to death but n			e to the cause of death? Probably 4X Unknown				
The law re	(4	Completed						24a. Was a autops perform	sy prior med? death	autopsy findings available to completion of cause of ? 'es 2 No	
ysician: T	director, page	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient	2 ER/Outpa	tient 3 DOA Ott	26. Place of Deat		ne) ence 6 X Other <i>(S</i>	Specify) HOSPICE	
. p .	neral	=	27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Y	28b. Tim	e of 28c. Injur			ow injury occurred	pecify HQDI TOD	
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After	ed in by	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (- At home, farm Specify)	street, factory, office		28f. Location (Si City or Town	treet and Number or n, State)	Rural Route Number,	
e Hospi 24 hou e Funer	letely fill	edical	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the best of n niner: On the basis of ex and manner stated	amination and/o	eath occurred at the ti r investigation, in my o	me, date and place, ppinion, death occur.	and due to the c red at the time, d	ause(s) and manner ate and place, and o	as stated. due to the cause(s)	
To the within 2	сош	X	29b. Signature and title of certifier			29c. Licens	se number		9d. Date signed (Mo	1. 1	
6			30. Name and address of person who				m	100 000			
Re	Sta gistra		31. Date filed (Month, Day, Year)		LANEY V	Spack	TIMONIUM	, MD 210	193		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** $\operatorname{\mathbb{P}}^{\mathsf{M}}$ JOHN THOMAS GUIFFRE October 29, 2006 6:45 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Cherry Lane Nursing Center Laurel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, NOV 1 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min Country) New York 1 ☐ M 2 ☐ F 1917 085-05-2978 88 Director Usual Residence of Decedent with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits ä 1√XYes 2 No r 28a-f sh notified Director MD Prince George's Laurel 10f, Zip Code 10g. Citizen of What Country? 10e Street and Number ms 23a or 7 15301 Alan Drive 20707 U.S.A. death v Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1XXes 2□No 1941 14 Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 'natural', or items dical Examiner m 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates: -1967 1 ☐ Yes 2 🖺 No Specify: Specify: <u>≽</u> White 3 X Widowed 4 ☐ Divorced Completed th and Mental Hygiene.
7 is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) United States Elementary/Secondary (0-12) College (1-4or 5+) Air Force Telecommunications Grade 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rose DeLuca Natale Guiffre 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dennis Thornton Executor 9106 Windemere Way Jessup, Maryland item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Department of Important: If it any injury or conce. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington National 11/29/2006 Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. 20707 M00770 313 Talbott Avenue Laurel, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Lymphoma, non-hodgkins months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Exami physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 ☐ Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ Congestive Heart Failure 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ ✗ o as e 2 autopsy performed? res 24.700 certificate 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 X Kursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2XXVo 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After t 1X Natural 5 Pending investigation n 24 hours after consider Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide *EXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi D 54853 October 30, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8317 Cherry Lane Danny Lee, M.D. Laurel, Maryland 20707 31. Date filed (Month, Day, Year) 32. gistrar's Signature State NOV n 8 2006

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month November 05,2006 6:00 P. M Margaret Blanche Gibbons /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Timonium Baltimore County | If Under 1 Year | If Under 24 Hrs. | B. Date of Birth (Month, Day, Year) | Feb. 25, 1918 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 21 F 139-07-3932 88 Yrs. Garwood, N.J. Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "natural", or iteme 23s or 28s-f show the Maxical Examinar must be notified at 1 Yes 20No Directo Maryland Baltimore County Cockeysville 10e. Street and Number 10g. Citizen of What Country? 10f Zin Code 10535 York Road 21230 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White δ 3 ☐ Widowed 4 XDivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0·12) College (1-4or 5+) 11 n/a Office Worker Factory lied 7 is marked othe traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental Pages 1 and 2 should be Philip J. Ryder Margaret Nolan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) or other train Hunt Valley, Maryland 21030 Mrs. Karen A. Murphy (Daughter) 10712 Tyrie Ave. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ② Cremation 3 ☐ Removal from State Department of Important: if any injury or once. Evans Funeral Chapel Nov. 9,2006 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Peaceful Alternatives Funeral&Cremation Ctr., P. A 2325 York Road Timonium, Maryland 21093 23a. Pagt. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Congestive **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Lary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner physician and s the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical as attending | IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐ Pregnant at time of death signed by the at d be detached for 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t lirector, page 2 s autopsy performed? 2 11No 1 ☐ Yes 2 ☐ No 1□ Yes Division of Vital Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To this After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after death.
To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Rel I. Mon Mg 189510 11/1/2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Business Cont. Dr. Reistanton Md Rob--+ Mon 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			1- For State of Maryland / Department Certification	ent of Health and late of Death		ne 2006	35213	
** _y	Physici	an	1. Decedent's Name (First, Middle, Last) John George Grosskopf	2. Date of Death Month	Day Year	3. Time of Death		
	/Medic	al		ity, Town, or Location of Deat	h	4c. County of Death		
	Funeral		Month	der 1 Year If Under 24 Hrs. hs Days Hours Min.	8. Date of Birth	9. Birth	MORE place (State or Foreign intry) ryland	
(6)	Director		213-10-8217		Nov. 1,	1916 Ma	rykana	
	show	'n	10a. State 10b. County 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location 10b. County 10c. City, Town or Location 10b. County 10c. City, Town or Location 10b. County 10c. City, Town or Location 10c.	timore			10d. Inside City Limits 1 ☐ Yes 2 No	
	28a-f	recto		Zip Code	10g	. Citizen of What Cou		
	23a or	ai D	9524 Perry Hall Blvd., Apt. 203	21236		u.s.A.		
036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, it a Medical Examinar must be notified at	by Funeral Director	1 Never Married 2 Married 1 XYes 2 No	cedent of Hispanic Origin? (Specify Cuban, Mexican, Puerl s 21X No Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Amer Black, White Specify:		
Baltimore, Maryland 21215-0036	ithin 72 ho ne. nen "natur Me lical	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	work done during most of wo Tuse retired)	rking 16	Sb. Kind of Business/Ir General E		
d 21	e filed w Il Hygier other th		12 Machin 17. Father's Name (First, Middle, Last)		me (First, Middle, Ma		revaron	
lan	Aental rked o	To Be	John Pancreatius Grosskopf	Anna	Moneius			
Mary	2 should and Men is marke			ess (Street and Number or Au Lenbauer Road,			p Code) 1087	
e, l	1 and Health Iem 27 other tr		20a Method of Disposition 20b. Place of Disposition //	Name of		c. Location - City or T		
timo	permit. Pages Department of I Important: If its any injury or o		1 🛱 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)			altimore,	_	
Bal	Depariment of the second of th			Belair Rd., 1			es .	
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the method, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury	ifficile CC		,	Approximate Interval Between Onset and Death	
Box 68760,	death certificate be executed e attending physicien and of for use as the burial-transit	n/Medical Examine	The initiated events resulting in death) Last Due to (or as a consequence of): d. IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deliv	very	
P.O. B	that the death	Physician/M	in the past 12 months? 1 Yes 2 No 9 Unknown 1 Live birth 2 Fetal death 3 Ectopic death 5 Other	c pregnancy (specify)		Month	Day Year	
	law requires tha as been signed 2 should be de	by	Part II. Other significant conditions contributing to death but not resulting in the underlying Myocardial Infarction	g cause given in Part I.		tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown		
Division of Vital Records,	The fa ate has page 2	Completed				/ prior to co	opsy findings available ompletion of cause of	
Z:	Physician: this certifical	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐	Othor	ath <i>Check only one</i> Home 5□ Residenc	ce 6 □Other (Spec	ify)	
n O	ting Ph I. After th funeral	on; To	27. Mayner of Death NO Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work?	28d. Describe how			
ivisio	if or Attending after death. Director: After d in by the fune	Certification;	2 Accident 3 Suicide 4 Homicide Accident Investigation Suicide Could not be determined 1 Yes 2 No	28f. Location (Stree City or Town, S	et and Number or Rui State)	ral Route Number,		
	Hospita 4 hours Funeral	edical Ce	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurr and manner stated.	red at the time, date and place tion, in my opinion, death occi	e, and due to the causurred at the time, date	se(s) and manner as a and place, and due	stated. to the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number		I. Date signed (Month		
	8.1		▶ Cefon Havel	D006178	9 NO	VEMBER,	2, 2006	
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrars-signature	DU06178 XXX Frankliv	Square	Drive F	Balto, MD 2100	
DH	MH 17 Rev 1/2		NOV 0 8 2006 Research			4		

GROSSKOPT, JOHN

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Linda Lee Gustaitus 4:35 P 3, 2006 November 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Center Towson If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Months 1 □ M 2 🕡 F 220-52-2876 56 Nov. 25. 1949 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10b. County 1 ☐ Yes 2 X No Maryland Baltimore. Baltimore 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code U.S.A. 10030 Crane Lane 21220 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White etc. 1 ☐ Yes 2X If Yes, Give Year or Dates: 2**X** No 1 Never Married 2 Married White 1 ☐ Yes 2X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Inventory Manager Auto Dealership 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bettu Schammel Edward Eugene Wiseman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 Beyda Court. Baltimore. MD 21236 Donna Elizabeth Wilson (sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 X Burial 2 □ Cremation 3 □ Removal from State Gardens of Faith Cem. 11/08/2006 Baltimore. Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licenses Rone 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final compo for compa nontres disease or condition resulting in death) Due to (or as a cons Juence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

ò be

23a

"natural", or Items 23a

the Medical

marked other than

d 2 should be fill hand Mental H ris marked ott

permit. Pages 1 and 2 Department of Health s Important: If item 27 is any injury or other tra

the

72 hours after

Baltimore, Maryland 21215-0036

Director

Funeral

Completed by

Be

Physician/Medical Examiner attending physician and for use as the burial-tran been signed by the s should be detached t Certification: To Be Completed by funeral After To the Hospital or Attendii within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Cause (Disease or injury that initiated events resulting in death) Last	c	
IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 □ Yes 2 N No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	23d. Date of delivery Month Day Year
Part II. Other significant conditions of	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
-		24a. Was an autopsy performed? 1□ Yes 2 5 No
25. Was case referred to medical	26. Place of Death	(Check only one)
examiner? 1 ☐ Yes 2 ∑ No	Hospital:	ne 5 Residence 6/10Other (Specify)
27. Manner of Death 1 StNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury Work? M 1 ☐ Yes 2 ☐ No	8d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	8f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier Certifying Ph	nysician: To the best of my knowledge, death occurred at the time, date and place, a	and due to the cause(s) and manner as stated.

State Registrar

AARDES 31. Date filed (Month, Day, Year) NUV 0 8 2006

(Check only

29b. Signature and title of certifier

32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chanles.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

			. 1000	State of Maryla	nd / Den:	artment of H	lealth and N	Mental Hygid	ene	
		•	For State Registrar	olalo ol maryla		rtificate of		_	2006	35215
			Decedent's Name (First, Middle,	Last) A · CC	1			2. Date of Death		3. Time of Death
Н	Physici /Medic		Charles	Griffin	UR			Month	Day Year	2 2 3 71
н	Examin		4a. Facility Name (If not institution,	// /	. /	4b. City, Town, o	r Location of Death		4c. County of Dea	
				5. Sex 7. Age (In vis	S. last birthday)	If Under 1 Year	If Under 24 Hrs.	R Date of Righ	nne	
	Funeral Director		2/3-52-2346	125M 2□ F	s. <i>iast birtnday)</i> Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Pay,)	(ear) 1348 M	rthplace (State or Foreign
		4	Usuel Residence of Decedent					Magest 17	1110 111	ey ma
	arylan show det		10a. State 10b. County	12	City, Town or Lo					10d. Inside City Limits 1 X Yes 2 □ No
	289-f	ecto	HARY And Number	ie DA	Himo			100	. Citizen of What C	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hyglene. Importent: If item 27 is marked other then "neturel", or Items 23e or 28e-f show many injury or other treumatic event, the Medical Examinal must be recilied at ance.	by Funeral Director	1905 E. 32	M street		10f. Zip Code	2/8	101	//SA	2
	ms 2:	nera	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.		lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - Am	
9	after or tte	/Fu	1 Never Married 2 ☐ Marrie			1 ⊡Yes 2. Ø No	Specify:	rican, etc.)	Black, Wh	. 1
21215-0036	within 72 hours ene. then "neturel", he Medical Era	d b	3 Widowed 4 Divorced	Year or Dates:				1 22	PHICH	W AMERICAN
5	in 72	Completed	15. Decedent's (Specify only highest	grade completed)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of work d)	ting 16	b. Kind of Business	s/Industry
212	d with jiene.	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Hom	e Impi	rocemen	et c	Self En	placed
	be filed tal Hygi d other event, I	Be C	17. Father's Name (First, Middle, La	ast)	1.7		18. Mother's Nam	e (First, Middle, Ma	iden Sumame)	
aryland	Menta Menta arked	ToE	Charles Griff	tin SR			HELEN	BARI	185	
Mar	2 shot and is m	1	19a. Informant's Name/Relationshi	p (Type, Print)	19b. Mailir	E 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	1 / / /		City or Town, State,	// -
-5	1 and Health em 27 ther t	-	20a. Method of Disposition	- 11101her 20b.	Place of Dispo	sition (Name of		Date 20	c. Location - City o	
Baltimore	Pages nent of I ent: If its ury or o		1 Burial 2 Cremation	3 □Removal from State		natory or other place	(e)		2 /	
Ē	permit. Pag Department Importent: any injury o		* 4 ☐ Donation 5 ☐ Other (Special Service Li	1//	1167760	(Remato) Name and Addre	of Facility	bers & C.	ITTONSVILLE 1 SCRUIC	MARYland
Ba	permi Departimpo Impo any ir		Maurey m.	College	R	Ancy m.	COATTACE	Streat K	al Service	MARYlAND 2129
			23a. Part I. Enter the disease, or c shock, or head failure. List of	omplications that caused the de-	ath. Po not ent					Approximate Interval Between
B	Pnysician		Immediate Cause (Final disease or condition	Renal -	faiker	,				Onset and Death
Н	/Medical		resulting in death)	Due to (or as a conse	equence of):					
	Examiner		Sequentially list conditions,	b. Septic	Shoc	K				2 weeks
	led Isit	Examiner	if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Une to for as a conse	mce out	Live	24-Ra	ereality;	Cilure	
, 	e be executed /sician and e burial-transit	Exar	that initiated events resulting in death) Last	c. Due to r as a conse	equence of):	700	SU NES	16 49 4	771476	
200	ate be executed hysician and the burial-transit	cal		d.		-515				5 WEST OF THE SEC.
89	rtifical ng phy as th		IF FEMALE:						818	
Вох	uth ce ttendii or use	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fe	tal death 3	Ectopic pregnancy			23d. Date of de Month	livery Day Year
0	ne de: the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of 9□ Unknown	death 5	Other (specify)		-		54,
P.O.	that the ed by detac	Ph	Part II. Other significant condition	s contributing to death but not re	sulting in the u	nderlying cause give	en in Part I.	23e. Did toba	cco use contribute t	o the cause of death?
ds,	w requires that the death certifica been signed by the attending ph should be detached for use as if	d b	HIV-Aids	*				1 □ Yes	2 X No 3 □ P	robably 4 Unknown
000	s beel	olete						24a. Was an	24b. Were a	utopsy findings available
Re	The la te has age 2	Completed by Physiclan/Med						autopsy performe 1 ☐ Yes 2 ☑	d? prior to death? No 1 ☐ Yes	completion of cause of
Division of Vital Records,	Physicien: The law requires that the death certifica this certificate has been signed by the attending phral director, page 2 should be detached for use as the	BeC	25. Was case referred to medical				26. Place of Deat	h (Check only one)	,110	2,5110
× ×	hysic his ce Il dire	ို	examiner? 1 ☐ Yes 2 💢 No		☐ ER/Outpatier		4 Nuising no		ce 6 □Other (Spe	ecify)
D U	ling P	<u>i</u>	27. Manner of Death 1 Natural 5 □ Pending		28b. Time of Injury	Worl	k?	28d. Describe how	injury occurred	
isi	Attending ir death. ector: After by the fune	lcat	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	ot be 390 Blace of loive. At	home farm str		Yes 2 □ No	28f. Location (Stre	at and Number or B	ural Route Number.
<u>≥</u>	after after Dire	Certification;	4 ☐ Homicide determin	building, etc. (Spec	city)	oot, radiory, onice		City or Town,		ara riouto riambor,
	To the Hospitel or Attending Physicien: The law within 24 bours after death. To the Funerel Director: Atten this certificate has completely filled in by the funeral director, page 2.		29a. Certifier 1 Certifying (Check only 2 Madical E	Physician: To the best of my kr	nowledge, death	occurred at the tim	ne, date and place,	and due to the cau	se(s) and manner a	s stated.
	he Hi in 24 ihe Fi iplete	edical	one)	xaminar: On the basis of examinar and manner stated.	nation and/or in					
	with To	Σ	29b. Signature and title of certifier	- MD		29c. License	e number	290	. Date signed (Mon	th, Day, Year)
	•		1 will	/ [24]		1/0	>-00		11/03/	~~~
	2		30. Name and address/of person w	no completed cause of death (Ite	om 23a) (Type,	Print)	ten A	R	2 Burne	Mn 21274
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Sign	nature	170 003		vertire, o	11104	0 - (1 - 62 /
	Registr	ar	MOV 0 8 5	2006 Marie	U Sp	all I				

			1 - For State Registrar	State of M	laryland		artmen					giene	006	35216
gt.			Decedent's Name (First, Middle, Last)				imouri	0 0, 1			Date of De	ath		3. Time of Death
	Physici /Medi		EMILY CROSS GR	ANT						ľ	Month VOV.	0 ^{Day}	2006	8:20a M
	Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. Coun								County of Deal	th		
3	g -	\$32 -	COLLEGE MANOR 5. Social Security Number 6. Sex	7 4	00 /le la	- 4 hi-th-do-1	LUT		VILL:		D : (B)		ALTIMO	
754	Funeral Director			144 030	ge (In yrs. Ia 90	Yrs.	Months	Days	Hours	Min.	Date of Birt Month, Pa 23/1	916	9. Birt Co M A R	hplace (State or Foreign ountry) YLAND
	D		Usual Residence of Decedent							ρ,	20, 1	310	11211	TEAND
	show	7	10a. State 10b. County	D.D.		Town or Lo								10d. Inside City Limits
	the M	Director	MD BALTIMO 10e. Street and Number	K E	LUTI	HERVI	LLE 10f. Zip	Code				10- 011-		1 ☐ Yes 2X No
	d within 72 hours after death with the Maryland Jiene. r then "natural", or lleme 23a or 28a-f show the Mudical Examiner must be mailled at		300 W. SEMINARY	AVENUE				211	93			USA	en of What Co	ountry ?
	death	Funerai		2. Was Decedent	Ever in U.S	. 13. y				gin? (Specif	y Yes or No		4. Race - Ame	
9	or Items	/Fu	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X If Yes, Give			r Yes, spec I ☐ Yes 2		n, Mexican. Specify:	i, Puerto Hic	an, etc.)	1	Black, White Specify: WH	
21215-0036	hours lural',	d by	3 Widowed 4 □ Divorced	Year or Dates:										
7	in 72	Completed	15. Decedent's Educ (Specify only highest grade	completed)		16a. Deced (Give life, L	lent's Usua <i>kind of wor</i> DO NOT us	rk done d	urina most	t of working		16b. Kin	d of Business/	Industry
212	d within giene. rr then "	mo:	Elementary/Secondary (0-12)	College (1-4or:	5+)	CHOI						CHU	JRCH C	HOIR
pu	be filed Ital Hygi of other	Bec	17. Father's Name (First, Middle, Last)						18. Mother	r's Name (F	irst, Middle,	Maiden S	Sumame)	
<u>Y</u> a	should t nd Ment marked umatic	Lo	JOHN EMORY CROS							LY LA				
, Maryland	od 2 lith a 27 ls		19a. Informant's Name/Relationship (Ty) DAVID CROSS	nephe	w	19b. Mailin 1405	g Address ESC	(Street a	nd Numbe R CT	or or Rural R DAV	oute Numbe VIS,	CA 9	Town, State, 2 95616	(ip Code)
Baltimore,	00		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R. 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cen	ce of Dispo: netery, cren CEN M	natory or ot	ne of ther place	, NO	Date V 7			ation - City or	Town, State
alti	근본분들 .		21. Signature of Funeral Service License	8	0111			d Addres	1		& SO			KE, MD
Ö	Depa Impo any ii		Villa (./a	ul		I	ENRY 6924	W. YOI	JENI RK RI	KINS D MON	& SO KTON	NS C ,MD.	2111	1.
			23a. Part1. Enter the disease, or complications, or heart failure. List only on	e cause on each II	ine.	Do not ente	er the mode	e of dying	, such as o	cardiac or re	spiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	de	MMA a conseque	the	- Als	seem	eis	time				Onset and Death
*	/Medical Examiner		resulting in death)	Due to (or as	a conseque	nce of):	0	,						
	10	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	à conseque	nce of).								
	ificate be executed physician and t is the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events											
oʻ	ate be executed hysician and the burial-transit	Ex	resulting in death) Last	Due to (or as	a conseque	nce of):								
8760,	ohysic the bu	Physician/Medical	d											
9 ×	eath certific attending p	/Me	IF FEMALE:	c. If yes, outcome	of pregnance	24								WW. new
Вох	death certific e attending p id for use as	cian	in the past 12 months?	1☐Live birth 4☐Pregnant at	2 Fetal d	eath 3	Ectopic pre Other (spe					23	ld. Date of deli Month	very Day Year
o.	at the death by the atte	hysi	1 ☐ Yes 2 ☑No 9 ☐ Unknown	9□ Unknown			O. 1101 (Opt							
S, D	as the gned	by P	Part II. Other significant conditions con	ributing to death b	out not resulti	ing in the un	derlying ca	iuse givei	n in Part I.		23e. Did to	bacco use	e contribute to	the cause of death?
ord D	w require been si should b									_ 1	1 □ Y	es 2 🗷	No 3□Pro	obably 4 Unknown
Vital Record	has b	Completed									24a. Was a	sy 📝	prior to c	topsy findings available ompletion of cause of
	n: The			_							perfor 1 Yes		death? 1 ☐ Yes	2 No
⋚	Physician: The fav this certificate has ral director, page 2	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 € No	ospital:		2/0		0.4	/		heck only or			
	ig Phy terthis nerald	n; To	27. Mann of Death	28a. Date of Inju (Month, Da		NOutpatient 8b. Time of	-	Bc. Injury Work	4 Nur		5 L Resid		Other (Specocourred	ify)
<u> </u>	를 돌 돌 글	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Da	y rear)	Injury	М		? es 2∐N	10				
Division	or Atten after deat Director: in by the	Certification;	3 ☐ Suicide 6 ☐ Could not 14 ☐ Homicide determined	28e. Place of Inj building, et	ury - At hom- c. (Specify)	e, farm, stre	et, factory,	office		28f.	Location (S City or Tow	treet and i	Number or Ru	ral Route Number,
	pital o		200 Continue of Section 19											
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edicai	29a. Certifier 1 ✓ Certifying Phys. (Check only one) 2 Medical Examin	er: On the basis of and manner sta	t examination	edge, death n and/or inv	occurred a estigation,	it the time in my opi	e, date and nion, death	d place, and h occurred a	due to the c	ause(s) ar date and p	nd manner as lace, and due	stated. to the cause(s)
	To the Vithin 2 To the Complet	Me	29b. Signature and une of critifier				29c.	License	number			29d. Date :	signed (Month	, Day, Year)
) (# (h	ESIM	1116	N/M	01	24	121		1	11/10	10%	//
	\o		30. Name and address of person who cor		leath (Item)	3a) (Type, F	rint)		, - /			10	1000	
	4		BRUCE ROSENBERG		21 WZ		st.	JITE	100	TOW:	SON, M	1D.	21204.	
*	Sta Registr	-	31. Date filed (Month, Day, Year) NOV 0 8 200)6 32. Hegistra	ar's Signatur	A A	cole							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month NOV 04, Marta Julia Gomez 2006 7:45 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Love Nest Assisted Living Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) JAN 28, 1922 5. Social Security Number 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🕁 F Couintry) Cuba 100-16-3698 84 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10d. Inside City Limits MD Anne Arundel Glen Burnie 1 ☐ Yes XXNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 109A First Ave 21060 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1X Yes 2□ No Specify: Cuban ģ 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Executive Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Manuel Arcas Adela Arcas ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RitaVictoria Gomez/Daughter 1600 Orchard Way Annapolis, MD 21409 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 11/06/06 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility C. Todd Dring Cremation Society of Maryland, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 21226 223. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence offi-Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown Month Day 4□Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ No 3 Probably 4 Unknown 1 Tes Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Assisted Hospital: 1 Yes 2 No 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) Living 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 ☑ Natural 2 ☐ Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 □Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. — Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Nonth, Day, Year) 10 o completed cause of death (Item 23a) (Type, Print) 30. Name and address of perso

Registrar

State

31. Date filed (Month, Day,

NUV

MD
32. Registrar's Signature

2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 006 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month Year 2006 HILDA BERNICE GASCH ovember /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Doctor's Community Hospital Prince George's Lanham If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 1–12–1927 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours 1 □ M 2 🕅 F Director 220-18-3162 79 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a, State 10d. Inside City Limits show r 28a-f sh notified 1 X Yes 2 No Directo Maryland Prince George's Berwyn Heights 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a once. 5901 Berwyn Road 20740 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: White Completed by 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working (life. DO NOT use retired) Receptionist/ Elementary/Secondary (0-12) College (1-4or 5+) 12 Switchboard Operator Private Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be finance and Mental F Victor Preston Clark ည Mary Hawbaker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Victor K. Gasch - Son 8607 Cunningham Drive, Berwyn Heights, MD 20740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 11/7/2006 Brentwood, Maryland 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Funeral Service Licenses 4739 Baltimore Ave., Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician MINAI disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner b51 Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner certificate be executed the burial-transi iding physician and resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗖 No for Month Day Year 4□Pregnant at time of death 9□Unknown 5 Other (specify) been signed by the should be detached 9 Unknown conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autonsy performe 1∐ Yes 2**X** No To the Hospital or Attending PhysIcian: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 X Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident

Box 68760. Ö م Records, Division or Vital

3 ☐ Suicide

(Check only one)

29b. Signature and ti

29a. Certifier

Medical

State

Registrar

4 Homicide

6 ☐ Could not be

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Modical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

8118 600d Luck Rd., Lanham, mi). 20104

29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print) ·M

Year) 31. Date filed (Month, Day,

NOV 0 8 2006

			1 - For Amend item#19a,	State of M perFH, G86	laryland / De l,11/17/06	oartmer ertificat	nt of F	lealth a Death	ind Me	ental Hy	giene	200	16	352	19
4	Physici	an	1. Decedent's Name (First, Middle, Las	*						2. Date of De Month		(/ear	3. Time of D	Death
	/Medi	cal	William T. Greenv		-)	4h Cih	Town	. I continu of	F Dooth	Novemb Novemb				1950	М
Mar.	Examir	ier	Holy Cross Hospit		,	4b. City,	TOWN, O	Location of Silve		oring	40.	County of Mont		ry	
	Funeral Director		214-20-4110	9x 7.A MIM 2□F	ge (In yrs. last birthda 82 Yrs.	Months		If Under 2 Hours	Min.	8. Date of Bir (Month, Da March 2	y, Year)		9. Birthpla Country M 1 SS		Foreign
	land ow It		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location							100	d. Inside City	v Limits
	Mary a-f she ified a	ctor	Maryland Montgo	mery	Sil	ver S	pring	g						1 □ Yes 2	
	or 28	Director	10e. Street and Number			10f. Zip					-	zen of Wh		•	
	eath v ns 23a must	Funeral	10000 Brunswick A				0910		in? (Cnoo	ifu Van ar Na		nited 14. Race -			
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces 1 X Yes 2 If Yes, Give Year or Dates:	No World	If Yes, spe		Specify:	Puerto R	eify Yes or No lican, etc.)	-		White, et	c.	
21215-0036	72 ho 'natur dical I	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Dec	edent's Usu ve kind of wo . DO NOT us	al Occup	ation during most o	of working	σ I	16b. Kii	nd of Busi	ness/Indu	stry	
121	within ene. than '	Jumo	Elementary/Secondary (0-12)	College (1-4or	5+)	. DO NOTU Isines	_				(Const	ructi	ion	
1d 2	e filed al Hygi other /ent, t	Be C	17. Father's Name (First, Middle, Last)	_					's Name ((First, Middle,					
ylar	Ments Ments arked atic ev	TO E	William Thomas Gr	eenville				Ca	ather	rine Lo	ouise	Wal	ker		
Maryland	d 2 sho th and ?7 Ism traum		19a. Informant's Name/Relationship (7 Camut / Catherine		/ 01/					Route Numbe					
ē,	s 1 an if Heal item 2 other		20a. Method of Disposition		20b. Place of Dis		ne of		Da			cation - Ci			
<u>=</u>	Page nent o ant: If ury or		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		' Arling	gton N netery		no1 i	Dece		Arli	ngto	n, Vi	irgini	a
Baltimore,	permit. Departi Importi any inj		21. Signature of Funeral Service Licen			22. Name ar Bethes Bethes	da-C	ss of Facility hevy (Maryla	Robe Case and 2	rt A. Inc.	Pump 7557	hrey Wis	Fune	eral H in Ave	ome/ nue
1	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	one cause on each	d the death. Do not e	nter the mod	le of dyin	g, such as c	ardiac or	respiratory ar	rest,		lr Ir	Approximate nterval Between Drays 7 Days	eath
	/Medical Examiner		resulting in death)		s a consequence of):		-								
		niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		e Divertion a consequence of).	uliti	s: Wi	th Per	rfora	ation			1	l6 Day	S
8760,	icate be executed physician and s the burial-transit	dical Examiner	that initiated events resulting in death) Last	Due to (or as	a consequence of):										
P.O. Box 6	ath certif attending for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3	□Ectopic pr □ Other (sp					2	3d. Date o			ar
Vital Records, P	quires that the de n signed by the a uld be detached t	by	Part II. Other significant conditions of Carcinoma, Pro		out not resulting in the	underlying c	ause give	en in Part I.						cause of dea	
900	law require as been sig 2 should b	Completed	Coronary Heart	Disease						24a. Was a		24b. We	re autops	y findings av	/ailable
Ž		Com	Diabetes Melli	tus Type	II					autop perfor 1□ Yes	sy med? 2⊠ No	dea	or to comp hth? Yes 2		se of
VII	certific rector,	Be	25. Was case referred to medical examiner?	Hospital:			Othe	NE'		Check only or					
	g Physer this eral dii	7: To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Inj			8c. Injury Work	4 🗆 IVUIS		e 5 ☐ Resid			(Specify)		
ion	ath. or: After ne funer	atior	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, De	ay Year) Injury	M		:? ⁄es 2 ∐ No			,,				
Division or	tal or Attending Physician: rs after death. al Director: After this certifica ed in by the funeral director, I	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of in building, e	jury - At home, farm, s tc. (Specify)	treet, factory	, office		28	f. Location (S City or Tow	treet and n, State)	l Number	or Rural R	loute Numbe	∍ <i>r</i> ,
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical	29a. Certifier 1 X Certifying Phy (Check only one) 1 Medical Exam	rsician: To the best iner: On the basis of and manner si	of my knowledge, dea of examination and/or ated.	investigation	, in my or	pinion, death	place, an	d due to the o	cause(s) date and	and mann place, and	er as state d due to th	ed. ne cause(s)	
	To To con	2	29b. Signature and title of certifier	Marie	Tail	290	D12			2		signed (A			06
7	241	-	30. Name and address of person who/o	ompleted cause of	leath (Item 23a) (Tyro	Print)	1114.	- 4- L					mper	2, 200	
_	10		George Sengstack,	M.D. 393	9 Ferrara	Drive	, Sil	lver S	prin	g, Mar	y1an	d 209	906		
	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 8 2	32. Resist	ar's Signature	Contract.	1								. %

			1 - For Stete Registrar	State of	Marylan		artment <i>rtificate</i>			ınd Me	ntal Hygid	ene 200	6 3	5220
	Physici /Medi		1. Decedent's Nam <i>e (First, Middle, La</i> Thurmon	Gilley	/					1	Date of Death Month OVEMber	Da 06 200		ime of Death
	Examir		4a. Facility Name (If not institution, giv 1818 Cremen Roa		nber)		4b. City, To		adena			4c. County of De		e]
	Funeral Director		5. Social Security Number 213-36-0220 Usual Residence of Decedent	Sex I⊠M 2□F	7. Age (In yrs. 6		If Under 1 Months		If Under 2 Hours	Min. M	Date of Birth (Month, Day arch 22	(ear) 1939	Birthplace (S Country)	State or Foreign VA
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 le marked other than "natural", or Items 23e or 28e-f show shi njury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10a. State 10b. County Maryland Anne A 10e. Street and Number 1818 Cremen Roa 11. Marital Status	d	10c. Cit	y, Town or Lo	10f. Zip C	ode	adena	2		g. Citizen of What	1 (Country?	side City Limits Yes 2X No
2-0036	2 hours after or setural, or iter	호	1 Never Married 2 X Married 3 Widowed 4 Divorced 15. Decedent's E	Armed For 1 Tes If Yes, Giv Year or Da	ces? 2 💢 No e	16a. Dece	Yes, specify 1 ☐ Yes 2 ☐ Jent's Usual (No Occupation	Mexican, Specify:	Puerto Rio	an, etc.)	Black, Wi	White, etc.	
Maryland 21215-0036	e filed within 7 I Hygiene. other than "n rent, the Med	Be Completed	(Specify only highest grade Secondary (0-12) 1 2 17. Father's Name (First, Middle, Last,	College (1	-4or 5+)	(Give	kind of work DO NOT use Mechar	retired)			First, Middle, Ma	Auto)	
arylar	2 should be and Mental le marked o	ToB	Thurmon C. 19a. Informant's Name/Relationship (Gilley Type, Print)		19b. Mailir	g Address (S	Street and	Els d Number		I .	Wilson City or Town, State		,
altimore, M	Pages 1 and 2 nent of Health ant: If Item 27 ury or other tra		Lydia Gilley 20a. Method of Disposition 1 Burial 2 Q Cremation 3 E 4 Donation 5 Other (Specif	Removal from S	State	1818 Place of Dispo emetery, crer Cro Cre	natory`or othe	of er place)	N	Date	0/	21122 Ic. Location - City of 1 Itimore,		
Balti	Departm Departm Importa eny inju		21. Signature of Funeral Service Licer	Stall	lena	22	3111	Address MOUT	of Facility ntain	Sta Road	allings L. Pasad	Funeral lena. MD	Home	
	Physician /Medical Examiner		23a. Parf.! Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a	or as a consequ	去		of dying,		ardiac or re	espiratory arrest	t,	Interv	eximate all Between trand Death
8760, <	ficate be executed physicien and strenge the burial-transit	dicai Examiner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	or as a consequ	·				_				
.O. Box 6	death certi e attending id for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		rth 2 Fetal int at time of de	death 3	Ectopic preg					23d. Date of d Month	elivery Day	Year
ords, P	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditions of	ontributing to dea	ath but not resu	ulting in the ur	nderlying caus	se given i	in Part I.		23e. Did tobac	cco use contribute		e of death?
al Records,	The ete h	Completed								_	24a. Was an autopsy performed	24b. Were a prior to death?		dings available n of cause of
of Vital	Physicia this certi al directo	To Be	I les Spario			ER/Outpatien		Other:	4 🗌 Nurs		heck only one) 5 Residence	e 6 ∐Other (Sp	ecify)	
Division of	r Attending Physician: ler death. Irector: After this certific by the funeral director.	Certification:	27. Manner of Death 1. Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	1	i, Day Year)	28b. Time of Injury	М		s 2 🗆 No	0	. Describe how			
<u>^</u>	pltal or ours afte ours afte		4 Homicide determined 29a. Certifier Certifying Ph	buildin	of Injury - At ho g, etc. (Specify	·) 			4-4		City or Town, S			Number,
	within 24 has mithin 24 has To the Fur	Medicai	one) 2 Medical Exam	uner: On the ba	sis of examinat	ion and/or inv	estigation, in	my opini	ion, death	occurred a	at the time, date	and place, and du	e to the ca	
	다 MET 2	<	29b. Signature and title of certifier	. //	2/2	1	29c. L	icense ni	umber	~/	29d.	Date signed (Mor	nth, Day, Ye	1ar)
	10		30. Name and address of person who	campleted oause	of death (Item	23a) (Type, I	Print)		Jos S) n.	171	A Auri	JUAN .	2100
	Sta Registr	_	31. Date filed (Month, Day, Year)		gisû r's Signat	ure	A.J.	>(0	1.70	7	N. V.	1	(Time)

DHMH 17 Rev 1/2001

ORIGINAL

35221

1 - For State Registrar

Physicia /Medica		IOSIF				GELB	SHTEYN		Month NOVEMBE	R 6	2006	3:40 A ^M
Examine				ive street and numb			4b. City, Town, o		eath	4c.	County of Death MONTGOM	
Funeral Director		5. Social Security N 220-33- Usual Residence of	5211	Sex 7. 1. M 2 □ F	Age (In yrs. la	st birthday, Yrs.	If Under 1 Year Months Days		1rs. 8. Date of Birlin. (Month, Da	y, Year)	Cou	place (State or Foreign intry) SELARUS
e Maryland	ctor	10a. State MD	10b. County MONTGO	MERY		NTGOM	eation ERY VILLA	IGE				10d. Inside City Limits 1 ☐ Yes 2 No
ath with the 23e or 28	rai Dire	10e. Street and Nur 18223 L		E CIRCLE			10f. Zip Code 2088				zen of What Cou	
s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. If the 17 is marked other than "naturel, or Items 23e or 28e-f show other traumatic event, it a Madical Examinar must be notified at	by Funeral Director	11. Marital Status 1 Never Marr 3 Widowed	ied 2 Married	12. Was Decedor Armed Force 1	es? No	5. 13.	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 1 No		(Specify Yes or No erto Rican, etc.)		14. Race - Ameri Black, White, Specify:	
within 72 ho ine. Ithan "natur e Modical	Completed	(Spec	15. Decedent's city only highest condary (0-12)		or 5+)	(Give life.	dent's Usual Occup hind of work done DO NOT use retire INEER	during most of v	working		nd of Business/fr	ŕ
lid be filed tental Hygierked other	To Be Co	17. Father's Name MENDEL	(First, Middle, La.			LBSHT		18. Mother's N	Name (First, Middle,	Maiden		
and 2 shouealth and Nealth and New 27 is mained New Traumained			SHARKOV	VA DAUGHT		15	DEAVEN C		BALTIMORE	, MD	21209	
nit. Page artment o ortant: If injury or I.			☐ Cremation 3 5 ☐ Other (Spec		ate ce	metery, cre IMORE		ONG. 11	/07/2006 SOL LEVIN	REI		WN, MD
Depril		23a. Part1. Enter t	the disease, or co	implications that cauly one cause on each	sed the death		3900 REIS	TERSTOW	N ROAD -	PIKE		
Physician /Medical Examiner		Immediate Cause disease or condition resulting in death)	(Final	_a. pheu	Monia as a consequ							Onset and Death
	Examiner	Sequentially list co cause. Enter Unde Cause (Disease or that initiated events resulting in death)	erlying injury s	с.	as a consequ							
death certificate be executed e ettending physicien and of for use as the burial-transit	an/Medical	IF FEMALE: 23b. Was deceden in the past 12			h 2 Fetal	death 3	⊒Ectopic pregnanc	y		2	23d. Date of deliv	rery Day Year
0 0 0	Physici	1 ☐ Yes 2 0 9 ☐ Unknown	□ No	4 ☐ Pregnar 9 ☐ Unknow s contributing to dea			Other (specify)	ven in Part I	23e Did t	obacco u		the cause of death?
w requires that the de been signed by the should be detached	eted by	none					andonying sauso gr		10,	Yes 25	ZNo 3□Pro	bably 4 Unknown
The lav	e Completed	25. Was case refe	rrad to medical						1 ☐ Yes	osy ormed? 2 No	prior to co death? 1 \(\text{Yes}	opsy findings available ompletion of cause of
nysicie nis certi directo	To Be	examiner?		Hospital: 1 / Inp	patient 2 🗆 8	ER/Outpatie	nt 3 DOA	200	Death <i>Check only o</i>		5 □Other (Speci	fy)
lending Preath. or: After the	Certification:	27. Manner of Dear 1 Natural 2 Accident 3 Suicide	th 5 Pending investigat 6 Could not	ion	Day Year)	28b. Time o Injury	M 1	ryat rk?]Yes 2 ☐ No	28d. Describe I	how injury	y occurred	
oltal or Att urs after d arel Direct	Certifi	4 Homicide	determine	ed 288. Flace o	, etc. (Specify)	reet, factory, office		City or Tou	wn, State))	al Route Number,
To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier (Check only one) 29b. Signature and	∠ Medicai Ex	Physician: To the basaminer: On the bas and manne	is of examinati	viedge, dea ion and/or it	th occurred at the ti evestigation, in my of	opinion, death o	ccurred at the time,	date and	and manner as a place, and due to a signed (Month,	to the cause(s)
± ₹ ± 8		> 2	Censhi	an completed	M.C						-	
Stat	10	30. Name and add	shue,	S/W/4 (of death (Item TROVE Strar's Signat	adu	Print)	Hospita	al , Lhu	ihe	rskung	1710
Registra				2006	EUS A	BY A	person					

			1 - For State Registrar	State of Mary				lealth and			71111	5 35	5222
	Physici /Medi		1. Decedent's Name (First, Middle, t	٠٤.			Gans		2. Date of De	Day	4 2006	, 200	of Death
1	Examir Funeral Director	ner	4a. Fecility Name (If not institution, g The Johns /topks 5. Social Security Number 212-90-7423	ns Hospital	n yrs. last birthday 39 Yrs.	1	Baltin der 1 Year	Location of De	irs. 8. Date of Birt		9. Bir	N/A	
	D	_	Usual Residence of Decedent 10a. State 10b. County	I MORE	c. City, Town or L		RSTOWN		00/00/	1907		10d. Inside	City Limits
	with the M or 28a-f be notifie	Director	10e. Street and Number 11966 LONG LAK		KE		Zip Code	21136		10g. Cit	izen of What C		es 2 💢 No
336	be filed within 72 hours after death with the Maryland ial Hyglene. d other than "naturel", or iteme 23a or 28a-f ehow event, tra Medical Exartinal must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces?	r in U.S. 13.		cedent of Hi becify Cuba 2 💢 No		(Specify Yes or No- erto Rican, etc.)		14. Race - Am Black, Whi	erican Indian,	
21215-0036	d within 72 hou giene. Ir then "nature Ir e Medicel E	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education trade completed) College (1-4or 5+)	(Giv	e kind of 1	use retired	turing most of v	vorking	16b. K	ind of Business	/Industry	
Maryland		To Be C	17. Father's Name (First, Middle, La:	st)	GA	NSLAV	ı	18. Mother's N	lame <i>(First, Middle,</i> TH	Maiden	Sumame)	GA]	INER
	nd 2 sulth ar		19a. Informant's Name/Relationship LAUREN GANSLAW	/ WIFE	1196	6 L01	NG LAK		Rural Route Numbe	-			5
altimore,	00==		20a. Method of Disposition 1	Removal from State	20b. Place of Disp cemetery, cre SHAAREI	TFIL(OH CEN	1. 11,	Date /06/2006	WO	ODLAWN	, MD	
Ba	permit. Pag Department Importent: any injury o		21. Agrandere of Funeral Reference	igen.		8900	REIS		SOL LEVI	PIK			
)	Physician /Medical		23a. Part1. Enter the disease, or shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)		Intracra					rest,		Approxim Interval B Onset an	etween
/60,	rate be executed xx x hysicien end xx x x x x x x x x x x x x x x x x x	dical Examiner	Soquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	ida Fin's	mbou Lym	yto p	enio				3 me	onths
	the death certificat r the attending phy ched for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	□Ectopic □ Other (pregnancy (specify)				23d. Date of de Month	livery Day	Year
2	law requires that the de as been signed by the 2 should be detached		Part II. Other significant conditions	contributing to death but no	ot resulting in the I	underlying	cause give	en in Part I.	23e. Did to		ise contribute to	o the cause of	
Ÿ	The larate has	Completed							24a. Was a autop perfor 1 ☐ Yes	sy	prior to death?	utopsy linding completion of 2 No	s available cause of
VII a	Physician: this certificantal director.) Be	25. Was case referred to medical examiner? 1 Yes 2	Hospital:	-5		Othe	VC'	eath (Check only or				
ö	ng Phy ter this neral d	ition: To	1 Yes 2 No 27. Manner of Death Natural 5 Pending 2 Accident investigati	28a. Date of Injury (Month, Day Ye	2 ER/Outpatie 28b. Time of Injury		28c. Injury Work	at	Home 5 Resid			icify)	
DIVIS	tal or Attendir rs after death. al Director: Af ed in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		At home, larm, st Specify)	treet, lacto	ory, office		28l. Location (S City or Tow			ural Route Nu	mber,
	To the Hospital or A within 24 hours after To the Funeral Direc completely filled in by	Medicai	29a. Certifier 1 Certifying F (Check only one)	Physician: To the best of m aminer: On the basis of exa and manner stated.	y knowledge, dea imination and/or in	th occurre	od at the tim on, in my op	e, date and pla pinion, death oc	ce, and due to the c curred at the time, o	ause(s) late and	and manner as place, and due	s stated. to the cause	(s)
)	Total	Σ	29b. Signature and title of certifier	Lun Medica	e Poció	2	9c. License		00 1		e signed (Mont		
_	JH		30. Name and address of person who Emily Sydnor, T	completed cause of death he Johns Hep	(Item 23a) (Type	Print)	,6001	VorthW	orfe Sheet	Ball	more, Me	ary land	121214
	Sta Registr			32. Registrar									

Patient known as cusile mant

Baltimore. Marvland 21215-0036

Division or Vital Records. P.O. Box 68760.

		State of Ma				Health and M		_	oie.	
		For State Of Ma	iyiaii	-	rtificate of			0 0	06	35223
	П	Decedent's Name (First, Middle, Last)					2. Date of Death	1		3. Time of Death
Physici /Medic		CYRILE		GR	ANT		November		Year	4.52 PM
Examin		4a. Facility Name (If not institution, give street and number)				or Location of Death		4c. County of	of Death	
· · · · · · · · · · · · · · · · · · ·		Sinai Hospital of Baltir			Baltin If Under 1 Year	noveat	4			N/A
Funeral Director		5. Social Security Number 6. Sex 7. Age	95	ast birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	By Date of Birth (Month Day 06/21/1	9°1′1	9. Birthp Cour	place (State or Foreign htry) MD
100	Ì	Usual Residence of Decedent					00/ 21/ 1			
arylan show d at	_	10a. State 10b. County	10c. City	, Town or Lo					1	0d. Inside City Limits 1
with the Maryland a or 28a-f show be notified at	Director	MD N/A		ВА	LTIMORE		46	- 022		
with tage or 2	Dir	10e. Street and Number 6317 PARK HEIGHTS AVENUE	# Δ 1	2	10f. Zip Code	21215		g. Citizen of W	nat Cour	USA
filed within 72 hours after death with the Maryland Hygiene. Hygiene, then "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	Funeral	11 Marital Status 12. Was Decedent E			Was Decedent of H	Hispanic Origin? (Spian, Mexican, Puerto	ecify Yes or No-			an Indian,
after or ite		Armed Forces? 1 Never Married 2 Married 1 Yes 2 N If Yes, Give	0		iryes, specify Cub 1 □ Yes 2 X No	san, Mexican, Puerto Specify:	Hican, etc.)		, White,	
nours ural"; Il Exa	d by	3 M Widowed 4 Divorced Year or Dates:						Specify:		WHITE
n 72 h	Completed	15. Decedent's Education (Specify only highest grade completed)	///	Give	dent's Usual Occup kind of work done DO NOT use retire	pation during most of work d)	ing	6b. Kind of Bus	siness/In	dustry
withi jiene. r than the M	omp	Elementary/Secondary (0-12) College (1-4or 5-	4		MEMAKER	,		OWN H	OME	
be filed within 72 ho tal Hygiene. d other than "natu event, the Medical	BeC	17. Father's Name (First, Middle, Last)			5.50	18. Mother's Name	e (First, Middle, M	laiden Surname	?)	DED.444
2 should be filed within and Mental Hygiene. is marked other than raumatic event, the M	To	BENJAMIN			DER	MAYME				BERMAN
2		19a. Informant's Name/Relationship (Type. Print) BILL GRANT / SON		1	-	and Number or Run DRIVE - B				Code)
s 1 and 2 of Health item 27 i		20a. Method of Disposition	20b. P		sition (Name of matory or other pla			Oc. Location - 0		own, State
9 0 = =		1 MBurial 2 □ Cremation 3 □ Removal from State 4 □ Domation 5 □ Other (Specify)				AMUNO 11/	6/2006	BALTIMO	RE.	MD
permit Pag Deparment Important: I any in ury o		21. Signature Funeral Service Ucensee	1		2. Name and Addre		SOL LEVI			
		Willall Duge			8900 RE					, MD 21208
		23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only on the second secon					or respiratory arre	st,		Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition resulting in death)	151)	ng po	inveat	uus.				zdays.
/Medical Examiner		Due to (or as a	consequ	uence of						Ü
	Jer	Sequentially list conditions, if any, reading to immodiate cause. Enter Underlying Cause (Disease or injury	ounsequ	isnos utiji:					- 0	
cuted	Examine	that initiated events								
te be executed ysician and e burial-transit		resulting in death) Last Due to (or as a	consequ	uence of):						
leath certificate leath curificate leath certificate leath of the for use as the k	dical	d							-	
r certif nding use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome programs of the program of the progra						23d. Date	of delive	erv
death e atte	icia	in the past 12 months? 1 Ves 2 Wo 9 Unknown]Ectopic pregnanc]Other <i>(specify)</i> _	у		Mon	th	Day Year
at the de I by the stached	hys	9 Li Unknown								
The law requires that the death certificate the has been signed by the attending phys age 2 should be detached for use as the	ģ	Part II. Other significant conditions contributing to death bu	t not resu	alting in the ui	nderlying cause giv	en in Part I.				ne cause of death?
w requir been si should	Completed									, _
The lav	ldmo						24a. Was an autopsy perform	red? pr	rior to cor eath?	psy findings available mpletion of cause of
		25. Was case referred to medical			<u></u>	26. Place of Deatl			□Yes	2⊠No
nysici	To Be	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ ☐ patier	nt 2 🗆	ER/Outpatier	nt 3 DOA Oth	or:	me 5 Reside		r (Specif	y)
ding Ph		27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day)		28b. Time of Injury	Wor	ry at rk?	28d. Describe ho	w injury occurre	ed	.
ttendi Jeath. Stor: A	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injured.	nt At ha	mo form str		Yes 2□No	20f Loopling (Ch	a a 6 a a a d A 6		I Davida Marakan
spital or Attendiours after death neral Director: / filled in by the f	Certification:	4 Homicide determined building, etc	. (Specify	/)	eet, lactory, office		28f. Location (Str. City or Town,	State)	r or Hura	ii Houte Number,
Hospital or Attend 24 hours after death e Funeral Director. etely filled in by the f		29a. Certifier 1 ertifying Physician: To the best o	f my kno	wledge, deat	h occurred at the ti	me, date and place,	and due to the ca	use(s) and mar	ner as s	tated.
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, I	ledical	(Check only one) 2 Medical Examiner: On the basis of and manner state	examina led.	tion and/or in			red at the time, da	ite and place, a	nd due to	o the cause(s)
vith To T	Σ	29b. Signature and title of certifier Torkital Ruman	M	0	29c. Licens	se number	29	d. Date signed	(Month,	Day, Year)
in.		10010101	ath (1)	3/ -00=\ /T	Drint)	-000.	A 1	100 9	20	06.
17		30. Name and address of person who completed cause of de	ath (Item	D C	H Wai	Mos pir	a) of	Bolti	m	010 :
Sta	ite	31. Date filed (Month, Day, Year) 32. Registr	s Signa	ture	1	1-2/01/	- 0	. July	, , ,	V
Registr	ar	NOV 0 8 2006 ▶	MAR.	, D.	Horses					

			1- State of Maryland / Dep	artment of Health and Mertificate of Death	ental Hygie									
	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Death Month	3. Time of Death								
	/Medic	cal	AARON Glick 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death								
H	Examin	ner	RUXTON PIKESVILLE NURSING HOME	PIKESVILLE		BALTIMORE								
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2 F 84 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth Month Day. Ye 02/04/192	9. Birthplace (State or Foreign Country) MD								
	ס		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	<u> </u>	02/04/132	10d. Inside City Limits								
	a-f sho	ctor		DALLSTOWN		1 ☐ Yes 2 🕅 No								
	s 1 and 2 should be filed within 72 hours after death with the Maryland feath and Mental Hygiene. If Health and Mental Hygiene. Itam 27 is marked other than "natural", or Itams 23s or 28s-f show other traumatic event, the Medical Exact instructive I colling at	Funeral Director	10e. Street and Number 3801 SCHNAPER DRIVE #424	10f. Zip Code 21133	10g.	Citizen of What Country?								
	ms 23	nera		Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I	cify Yes or No-	14. Race - American Indian,								
36	rs after ", or Ita	by Fu	1 Never Married 2 Married 1 1 Xi Yes 2 No 1 Yes 2 No 1 Yes Give ARMY Year or Dates:	1 ☐ Yes 2 💢 No Specify:	rican, etc.)	Black, White, etc. Specify: WHITE								
9	2 hou	ted t	15. Decedent's Education 16a. Dece	edent's Usual Occupation	16b	. Kind of Business/Industry								
7	vithin 7 ne. han "r	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of workir DO NOT use retired) SMAN		CLOTHING								
2	illed v Hygie othar 1	Be Co	17. Father's Name (First, Middle, Last)		(First, Middle, Maid									
Maryland 21215-0036	should be ind Mental I marked o	ToB	BENJAMIN GLIC			KLAVENS								
	and 2 shealth and n 27 is n			ing Address (Street and Number or Rura. DORAY COURT - WOOD										
altimore,	ges 1 and 1 of Health If item 27 or other tr	1	20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, cre	osition (Name of Dimatory or other place)	ate 20c.	Location - City or Town, State								
Ē	7 :t:		`4 ☐ Deinstion 5 ☐ Other (Specify)	MUNAH)AITZ CHAIM 11		HALETHORPE, MD								
Ba	permit. I Departm Importar any inju		21. Signature Funeral Service Livenska 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208											
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line			Approximate Interval Between								
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	ria		Onsel and Death								
	Examiner		Due to (or as a consequence of):											
7	be is	liner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uscaso or injury)											
V.	sate be executed by sician and the burial-transit	Examiner	that initiated events c. Due to (or as a consequence of):											
8760,	cate be physicia the bur	dlcal	d											
Box 6	eath certific attending p	n/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery								
O. B	The law requires that the death certific tle has been signed by the attending p page 2 should be detached for use as s	Physician/Me		□Ectopic pregnancy □ Other (specify)		Month Day Year								
0	res that the de igned by the a be detached t	by Ph	Part II. Other significant conditions contributing to death but no resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?								
ords	w require been sig should b		rul staye fartunson	4	1 Tes	2 No 3 Probably 4 Unknown								
Division of Vital Records,	rsician: The law s certificate has b lirector, page 2 si	Completed			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?								
a		Be Co	25. Was case referred to medical	26. Place of Death	1 ☐ Yes 2 ☑ (Check only one)	No 1 ☐ Yes 2 ☐ No								
<u>ک</u>	hysic this ce al direc	은	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie			6 □Other (Specify)								
on	Attanding Physician: r death. actor: After this certifici by the funeral director.	tlon:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day Year) Injury	of 28c. Injury at 2 Work? M 1 ☐ Yes 2 ☐ No	8d. Describe how in	jury occurred								
Nisi	I or Attano after death Diractor: I in by the	ertification;	3 ☐ Suicide 4 ☐ Homicide 5 ☐ Could not be building, etc. (Specify)	reet, factory, office 2	8f. Location (Street City or Town, Str	and Number or Rural Route Number,								
	Hospital o	0	29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place, a	and due to the cause	(c) and manner as stated								
	T 42 r 5	ledical	(Check only 2 Medical Exeminer: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurre	d at the time, date a	and place, and due to the cause(s)								
)	To the within 7 To the comple	Σ	29b. Signature and title of certifier	29c. License number 7) 27 5 6 9		Date signed (Month, Day, Year)								
	A		30. Name and address of person who completed cause of death (Item 23a) (Type	, Print)	7	Rd 2/208								
	Cto	to	31. Date filed (Month, Day, Year) 32. Registrar's Signature		· nec	14 21208								
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	boarde										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. NoZ U U 6 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Carlos (nmn) Goncalves 10:15 ₽[™] /Medical November 3. 2006 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Havre de Grace
If Under 1 Year | If Under 24 Hrs.
Months Days | Hours | Min. Harford 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**5**0 M 2□ F Director Vrs 030-52-4189 57 Jul. 27, 1949 Portugal Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at 10:15 PM Director Maryland Harford Abingdon 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 342 Delmar Ct. 21009 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 Yes 20 No Specify. 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 4 Construction Worker Landscaper 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If Item 27 is marked oth any linjury or other treumatic event ODEs. Be 18. Mother's Name (First, Middle, Maiden Surname) Venancio (nmn) Goncalves Maria Celeste Goncalves 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bertilia Goncalves/ Wife 342 Delmar Ct., Abingdon, Maryland 21009 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harford Memorial Grdn 11-7-06 Abendeen, MD 21. Signature of Funeral Service Licensee 22 Name and Address of Facility McComas Funeral Home, P. A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1317 Cokesbury Rd., Abingdon, Maryland 21009 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Small Cell hung Carcinoma Domonths /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. ettending physicien Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ cate has been sig , page 2 should b 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural s after deau. 5 Pending investigation М 1 Tyes 2 TNo 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Clastic only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 40054439

4

November 3,2006

State Registrar incert A Giminaro Do 32. Registrar's Signature 8 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4B North Ave \$310 Bel Arrind 21014 books

November 3,2006

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Physician **Physici** Vear OLIVER LARRY HOLMES October 0 30 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3310 Sudlersville S. Laurel Anne Arundel If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1XM 2□F 69 31, 1937 213-36-2180 Director Aug. Maryland Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Ex∞miner must be notifled at 1 □Yes 20XNo Director Brunswick NC Winnabow 10g. Citizen of What Country? 10e Street and Number 10f Zip Code Gable Oaks Court 28479 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 🏋 🖾 Married 1 ☐ Yes 2 No 3altimore, Maryland 21215-0036 Specify Specify: White ۵ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Field Coordinator d 2 should be filed with and Mental Hygier 7 is marked other th Gas & Electric 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Oliver Wendell Holmes Myral Beavers ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is n any Injury or other traun Virginia L. Holmes /Wife 805 Gable Oaks Court, Winnabow, NC 28479 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 K Cremation 3 □Removal from State 11/6/2006 West Arundel Crem. 4 ☐ Donation 5 ☐ Other (Specify) Odenton, MD 21. Signa of Funeral Service Licensee Donaldson Funeral Home, P.A. 22. Name and Address of Facility M00160 313 Talbott Avenue, Laurel, MD 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Lung Cancer Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Juseass or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ cate has been sig , page 2 should b 1 XYes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate 2 □**X**No 2 No Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director: 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 Homicide XXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Fo the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D45014 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Isabella Martire, MD 8343 Cherry Lane, Laurel, MD 20707 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] [] [] 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Edna Catherine Helfrich November 04,2006 4:30 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Anne Arundel County Annapolis | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Dec. 26, 1919 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 XF 86 Yrs 203-09-0555 Allentown, PA. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits 1 Tyes 2 TNo Completed by Funeral Director Maryland Baltimore County Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1904 Snyder Ave. 21222 United States 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify Specify: White 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coflege (1-4or 5+) n/a Bank Teller Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Clarence Schwartz Bertha Ritter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Judith Ann Mennit (Dau.) 712 Old Love Point Road Stevensville, MD. 21666 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 12 Burial 2 ☐ Cremation 3 ☐ Removal from State Woodland Cemetery Nov. 07,2006 Coopersburg, PA. 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name and Address of Facility}
Peaceful Alternatives Funeral&Cremation Ctr.,P.A.
2325 York Road Timonium, Maryland 21093 21. Signature of Funeral Service L 23a. Part. Enleythe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Approximate Interval Between fmmediate Cause (Final disease or condition resulting in death) Onset and Death 10 5000 Due to far as a consequence Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or infury that initiated events resulting in death) Last Due to (or as a consequence IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months: 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Denknown 1 ☐ Yes 2 ☐ No.

Physician /Medical Examiner

physicien and s the burial-transit

35

950

ō

ed by the a

To the Hospital or Attending Physician: The law requires that the deal "certificate be executed

Box 68760.

Records, P.O.

Division of Vital

permit.
Deportrimports
any nju

Funeral

Director

r then "natural", or iteme 23a or 28a-f ehow the Modical Examinar must be notified at

Ith and Mental Hygie 27 is marked other r treumatic event, it

mit. Pages 1 and 2 should be fit partment of Health and Mental Hippritant: If them 27 ie marked ott y injury or other treumatic even

with the Maryland

filed within 72 hours after death

Baltimore, Maryland 21215-0036

Examiner Completed by Physician/Medical Be 2 Certification:

Hospitaf: 1 Inpatient

24a. Was an autopsy performed? 1 Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2**X**XVo

26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Injury 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier

3□ DOA

29b. Signature and title of certifier

25. Was case referred to medical examiner?

1 ☐ Yes 21 No

27. Manner of Death

1 X Watural

2 Accident 3 Suicide

4 Momicide

29c. License number D22507 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death viern 23a) (Tyl. e, Print)

Elizabeth M. Kingsley, 1.0 Love Point Road, Stevensville, Maryland M.D.

State Registrar

5 Pending investigation

6 ☐ Could not be

31. Date filed (Month, Day, Year) 32. Register NOV 0 8 2006

within 24 hours after death.

To the Funerel Director: Af

Medical

2 XER/Outpatient

28b. Time of

			State of Maryland / Departm	nent of Health and Moate of Death	lental Hygier	
	Physici /Medic Examin	al	11 21 0	City, Town, or Location of Death	2. Date of Death Month	Day Year 3. Time of Death 3 0 6 10 A 4c. County of Death BAH MORE
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If U	Inder 1 Year If Under 24 Hrs. This Days Hours Min.	8. Date of Birth (Month, Day, Yea	9 Birtholace (State or Form
Baltimore, Maryland 21215-0036	Hygir other ent.	To Be Completed by Funeral Director	10a. State 10b. County 10c. City, Town or Location Maryland Baltimore Baltimore 10c. Street and Number 8816 Dearborn Drive 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Was Decedent Ever in U.S. Ar	Altimore 1. Zip Code 21236 Decedent of Hispanic Origin? (Spirispecify Cuban, Mexican, Puerto es 212 No Specify: Usual Occupation of work done during most of work of the during most of work of the during most of work of the during most of work of the during most of work of the during most of work of the during most of work of the during most of work of the during most of work of the during most of work of the during most of work of the during most of work of the during most of work of the during most of work of the during most of work of the during most of the during most of work of the during most of work of the during most of the during most of the during most of the during most of the during most of the during most of the during most of the during most of the during most of the during most of the during most of work of the during most of the during most of the during most of the during most of the during most of the during most of the during most of the during most of the during most of the during most of the during most of the during most of the during most of the during most of the during most of the during most of the during mos	actify Yes or No-Rican, etc.) 16b. 16b. 16c (First, Middle, Maidle, Et E. (Sual Route Number, City Sedale, MD) 20c. 6/2006 Ball	rname Unknown) y or Town, State, Zip Code) 21237 Location - City or Town, State Ltimore, Maryland
Box 68760, path cardificate be executed in	ding ph	Physician/Medical Examiner	III tile past 12 months:		or respiratory arrest,	23d. Date of delivery Month Day Year
P.O.	te hes been signed by the age 2 should be detached	Completed by Physi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underly		1 Yes 24a. Was an autopsy performed	o use contribute to the cause of death? 2 No 3 Probably 4 Unknow 24b. Were autopsy findings availab prior to completion of cause of death? No 1 Yes 2 No
Division of Vital Records,	leath. tor: After this certific the funeral director,	Certification; To Be C	27. Manper of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined with the county of the	28c. Injury at Work? 1 Yes 2 No	me 5 Residence 28d. Describe how in	6 □Other (Specify) jury occurred and Number or Rural Route Number.
Div To the Hospital or		Medical Cert	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investig and manner stated. 29b. Signature and title of certifier 30. Nam and address of person who completed cause of death (Item 23a) (Type, Print)	urred at the time, date and place, ation, in my opinion, death occurred 29c. License number	ed at the time, date a	(s) and manner as stated
DHMF	Sta Registr	ar	DR. SALLARIS ANASTASTOS 9000 FTAO 31. Date filed (Month), Day, Year) NOV 0 8 2006 ORIGINAL	,	riva Balt	HIMORE,MD2123

HOEHAI, CARL

State of Maryland / Department of Health and Mental Hygien [] [Certificate of Death 2. Date of Death i. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** 2006 3:15p. 11 03 Hall /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** N/A Baltimore 3800 West Belvedere Ave #505 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 💢 F 97 Director NC 239**-**58-4274 Usual Residence of Decedent with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Itama 23e or 28e-f show Baltimore Yes 2 No MD Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? U.S.A. 3800 West Belvedere Ave #505 21215 death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian be filed within 72 hours after d ital Hygiene. Id other then "neturel", or Item Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🌠 No Specify. Black þ 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Private Domestic Worker 9th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill iment of Health and Mental H tant: If itsm 27 Is marked other Katie Hawkins George McCree 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3800 West Belvedere Ave #1018, Balto, Allen Hall-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State ND Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or once. 11/9/06 Baltimore Co, Md Woodlawn 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a: Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** day NEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of) Failure Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ed by the a 1 ☐ Yes 20K No 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ No 3 Probably 4 Unknown been significant 1 Yes Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 2 No certificate 1 TYes fo the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home Residence 6 Other (Specify) After the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 atural 5 Pending within 24 hours after death.

To the Funerel Director: After the funerel by the f 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 11-7-06 D21344 30. Name and address of person who completed cause of death (Item 23a) (Type Print) 2717 Hammarch BAZ 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 0 8 2006 NOV Registrar

	1	For State Registrar	State of	Marylar	nd / Depa <i>Ce</i> a			ealth a Death	and M	-	gien Reg. N		5	35230
Discripto		1. Decedent's Name (First, Middle, La	est)							2. Date of De Month	a th Da	av)	'ear	3. Time of Death
Physiciar /Medica		LOUIS C	•	HORT	ON, SF	-				NOVEMBI		, 200		6:20 P
Examined Funeral Director	1		H & REHA	BILITA	TION . last birthday) Yrs.	F	'ORES'	T HIL	L	8. Date of Bir (Month, Da 08/22/		HARF	ORD	lace (State or Foreig
2		Usual Residence of Decedent		10.0										
then "naturel, or items 23a or 28a-f show the Model Examinar must be notified at		10a. State 10b. County		10c. C	ity, Town or Lo	ocation							1	0d. Inside City Limit 1 ☐ Yes 2X N
Page 1	25	MD Harfo	rd	В	el Air									
Sor S	2	10e. Street and Number	-				p Code				-	itizen of Wh	at Cour	itry?
1	2	555 S. Atwood R	Dad 12. Was Dece	dent Ever in I	IS 13		1014	spanic Orio	rin? (Sne	cify Yes or No		.S.A. 14. Race -	Americ	an Indian
diesi Examiner must be notified at	Dy run	1 ☐ Never Married 2 🌠 Married 3 ☐ Widowed 4 ☐ Divorced	Armed For 1 XYes If Yes, Give Year or Da	ces? 2 🗆 No		If Yes, spi	ecify Cuba	n, Mexican Specify:	, Puerto I	Rican, etc.)			White,	etc.
inches Potos	Completed by	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Dece	kind of w	ork done d	turina most	of workir	na	16b.	Kind of Busi	ness/Ind	dustry
	ig .	Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	DO NOT	ise retired)		.5				
5	5	12	2		Sa	lesma	n						gist	er Sales
0	B	17. Father's Name (First, Middle, Last	²)					18. Mother	r's Name	(First, Middle	Maide	n Sumame)		
F	9	Louis H. Horton								ene Cox				
		19a. Informant's Name/Relationship								l Route Numb				
	ļ	David W. Horton	(son)	205				rive -		l Air,		yLand location - C		1014
5		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 E	Removal from S	state	Place of Dispo cemetery, crei	matory or	other plac						,	
	L	4 □ Donation 5 □ Other (Speci	(y)	Ga	rdens o				-				•	Marylabd
Any injury or other treument event, many page.	.	21. Signature of Funer Service Light	nsee saadn	5										Home, P.A nd 21087
Tal-transit	cical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	or as a conse	quence of:	erw.	dy	Th						
by Dhyelelelan/Mac	Fnysician/med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		nth 2 ☐ Fet untattime of	al death 3	Ectopic (23d. Date Month		ry Day Year
ì	ò	Part II. Other significant conditions	contributing to de	ath but not re	sulting in the u	nderlying	cause give	en in Part I.			obacco Yes 2		ute to th	e cause of death?
1	ala									04- 146-		045 144		
	completed	DS Was and returned to medical	1							1 Tes	osy irmed? 2 \ N	prie	or to con ath?	psy findings available pletion of cause of 2 No
P Bo	0 06	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:		15510		Othe			(Check only o				
	2	27. Manner of Death	28a. Date o		ER/Outpatier 28b. Time o		28c. Injury Work	at Nur		ne 5 Resi				′)
1		1 Natural 5 Pending 2 Accident Investigation		n, Day Year)	Injury	М		k? Yes 2∐N				•		
19141	Medical Certification:	3 Suicide 6 Could not 8	28e. Place	of Injury - At h g, etc. (Spec	nome, farm, str ify)	reet, facto	ry, office		2	28f. Location (City or To	Street a vn, Sta	nd Number 'e)	or Rura	l Route Number,
Joseph	edical	29a. Certifier 1 \(\sum \) Certifying P (Check only one) 2 \(\sum \) Medical Exa	hysician: To the miner: On the ba and mann	sis of examin	owledge deat ation and/or in	h securio vestigatio	tat the tin	ia date à ic pinion, deat	d Jane 3 th occurre	and due to the ed at the time,	date ar	i) and Irani nd place, an	er as st d due to	the cause(s)
Modinal Careffica	Ĕ	29b. Signature and title of certifier				29	c. License	number	-		29d. D	ate signed (Month,	Day, Year)
		1 David S	D				03	225	5		No	Jem L	0, (· LOLE
1		30. Name and address of person who												0
		DR. DAVID DUNN -				D, SI	JITE	106 -	BEL	AIR, 1	1D 2	1014		
State	е	31. Date filed (Month, Day, Year)	31 Re	gistrar's Sign		and i								

			For State	State of	Maryland	-	artment of H		d Mental F	lygiene Reg. No.	000	35231
			Registrar 1. Decedent's Name (First, Middle, Last	t)			inoute or i		2. Date of		000	3. Time of Death
	Physici		Helen B. H	auser					Nov.	1, 200		9:30 P M
	/Medic Examin		4a. Facility Name (If not institution, give		ber)		4b. City, Town, or	Location of D			County of Deatl	
			Pickersgill Reti	rement	Communit	y	Tow	son			Balti	more
	Funeral		Social Security Number 6. Se	x □M 2XF	7. Age (In yrs. las		If Under 1 Year Months Days	If Under 24 H		Birth Day, Year)	9. Birth	nplace (State or Foreign untry)
L	Director		187-09-2351	JM ZIAIF	94	Yrs.			Aug.	16, 19	912 PA	
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, 1	Town or Lo	cation					10d. Inside City Limits
	d sho	ō	MD Balti	more	Тот	son						1 ☐ Yes 2 🛣 No
	the 28a	Director	10e. Street and Number	more	10%	75011	10f. Zip Code			10g. Citi	zen of What Co	untry?
	3a or		615 Chestnut Ave	•				21204			USA	46
	death	Funerai	11. Marital Status	12. Was Dece	dent Ever in U.S.	13. V	Vas Decedent of Hi Yes, specify Cuba		(Specify Yes or	No-	14. Race - Amer	
9	within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28a-f show ha Madical Examinar must be notified at	/Fu	1 Never Married 2 Married	1 Tes	2X No			Specify:	Jeffo Mican, etc.)		Black, White Specify: Wh	
8	ural',	d by	3 X Widowed 4 □ Divorced	Year or Da	tes:						Specify. WI	ite
5	"nat	Completed	15. Decedent's Edi (Specify only highest grad			(Give	lent's Usual Occupa kind of work done o OO NOT use retired	luring most of	working	16b. Kii	nd of Business/I	ndustry
12	within ene. then	duc	Elementary/Secondary (0-12)	College (1-	4or 5+)	Buye		/		Mali	ns Dept	Store
<u>Б</u>	filed Hygi other ent, I		17. Father's Name (First, Middle, Last)			Duye	·L	18. Mother's	Name (First, Mid			beore
Maryland 21215-0036	fental fental rked tic ev	To Be	George Zimmerma	n				Johann	nah Diez			
ary	should have some		19a. Informant's Name/Relationship (T			19b. Mailin	g Address (Street a	and Number or	Rural Route Nu	mber, City o	r Town, State, Z	ip Code)
	and 2 salth n 27 i		Elaine B. Gehris/	Daughte	r	8343	Tally Ho	Road L	uthervi	11e, M	D 21093	2
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ I	Removal from S	20b. Plac	e of Dispos	sition (Name of patory or other place	e) Nov	Date 7. 9,	20c. Lo	cation - City or 1	own, State
Ë	Pag ment tant: jury		* 4 ☐ Donation 5 ☐ Other (Specify,		Memo		alley alley Gardens	_	2006	Tin	onium,	MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural; or items 23a or 28a-1 show any injury or other traumatic event, the Madical Examinar must be notified at one.		21. Signature of Funeral der tice Licens	ichael	J. Flagl	e Le	Name and Address mmon Fund W. Pador	eral Ho	ome of D	ulaney	Valley	, Inc.
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that ca	used the death.	Do not ente	er the mode of dying	g, such as card	diac or respirator	y arrest,	E E E E E	Approximate Interval Between Onset and Death of it ys
	Physician		Immediate Cause (Final disease or condition	. 1	1spir	nt.	on ou	1000	renia			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequer	nce of):	- 1		0 1	- /	S. 50 .	in in Att.
6	Lammer	_	Sequentially list conditions,	b	e Ve Ve	01	0-pu	Jul La	est di	1192	zen	morang
	D TE	line	rr any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due 10 (6	s as a consequer	nos or).	-	0				(10101)
_	and al-trar	Examiner	that initiated events resulting in death) Last	c. Due to (c	or as a consequer	nce of):						george
8760,	icate be executed physician and sthe burial-transit	dicai E		d								
687	ificate g phy as the			u .								
Вох	eath certific attending p	Z.	IF FEMALE: 23b. Was decedent pregnant		ome of pregnance		Estania - reasan			2	3d. Date of deliv	very
	The law requires that the death certificate be executed at the been signed by the attending physician and page 2 should be detached for use as the burral-transit	by Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No		int at time of deat		Ectopic pregnancy Other (specify)			-	Month	Day Year
<u>Р</u> О	that the di ed by the detached	Phy	9 Unknown									
	ires tha signed	þ	Part II. Other significant conditions co	ntributing to de	ath but not resulti	ng in the un	iderlying cause give	n in Part I.				the cause of death?
oro	w requir been si should	ted							- '	Yes 2	1N0 3 Pro	Dably 4 Unknown
Vital Records,	e taw has b	Completed							_ 24a. W	itopsy	24b. Were aut prior to c death?	opsy findings available ompletion of cause of
E F	ding Physician: The th. h. After this certificate ha funeral director, page								1 ☐ Ye	nformed? s 2 No	1 Yes	2 No
Ħ	slciar certif recto	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:			Othe	1	Death (Check on			
o	Physic this aral di	: To	27. Manner of Death	28a. Date o	Injury 28	VOutpatient Bb. Time of	28c. Injury	ataursin	g Home 5 Re 28d. Descrit			rfy)
Division of	nding tth. :: Afte	atio	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month	, Day Year)	Injury	Work M 1 □ Y	:? /es 2 □ No				
Vis	Attendii er death. rector: A by the fu	ifica	3 Suicide 6 Could not be 4 Homicide determined	28e. Place	of Injury - At home g, etc. (Specify)	e, farm, stre	eet, factory, office		28f. Location	n (Street and Town, State)	d Number or Rui	al Route Number,
	rs effe	Certification:	Tiomodo	Dallall	g, etc. (<i>Specity</i>)				Only of	State)		
	To the Hospital or Attending Physician: within 24 hours efter death. To the Funeral Director: After this certific completely filled in by the funeral director, to	Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medicel Exemi	rsicien: To the iner: On the ba and mann	sis of examinatior	edge, death n and/or inv	occurred at the timestigation, in my op	e, date and pla inion, death of	ace, and due to t ccurred at the tim	he cause(s) ie, date and	and manner as place, and due	stated. to the cause(s)
}	To the To the comp	Σ	29b. Signature and title of certifier	ny As	ly.	mo	29c. License	number 5 205		29d. Date	signed (Month	Day, Year)
	13		30. Name and address of person who could be a leave to the country of the country	ompleted cause	of death (Item 2:	3a) (Type, I	Chal	es St.	Balts	-md	2,20	4
	Sta	te	31. Date filed (Month) Part Year)	32. Rg	strac's Signatur	Constant	A maria					
	Registr	4	1407 0 8 5	เกกค	Strac's Signatur	X R	08462					
DH	MH 17 Rev 1/20	001			No.	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 18 per fh e861 11-8-06 vt. State of Maryland? Department of Health and Mental Hygiene 1 - For State Registrar Reg. N2 0 0 6 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Month Year **Physician** Hil oanna. 01:20 N 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel 7. Age (In yrs. last birthday)

14 Yrs. Months Days Hours Min. (Month, Day, Year)

14 Yrs. Months Days Hours Min. (Month, Day, Year) 6. Sex 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 215.30.3896 1 ☐ M 2 😿 F MD Director Usual Residence of Decedent the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show id 2 should be filed within 72 hours after deeth with the Maryla thand Mental Hygiene.
27 is marked other then "netural", or Items 23e or 28e-f ehov traumatic event, the Madical Examiner must be notified at Anne Anundel MID Ddenton 1 ☐ Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 110 Court 21113 USA iason 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Domestro Homemaker 11th grade 18. Mother's Name (First, Middle, Maiden Sumame)

Mary L. Jackson 17. Father's Name (First, Middle, Last) Be William Jackson permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked any Injury or other traumatic events. Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son Hill 110 Liason Court Scott MD Odenton 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1

Burial 2 ☐ Cremation 3 ☐ Removal from State 11.06.06 Garnson Forest 4 ☐ Donation 5 ☐ Other (Specify) Owing Mills, MD 22. Name and Address of Facility Vaugun C. Greene Faneral Services 21. Signature of Funeral Service Licensee 4905 York Road Baltimone MD 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) COLON CANCE Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physicien and burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the sate hes been signed by the attending page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certification; To Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate 2 No 2 No 1 Yes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1x Inpatient 2 ER/Outpatient 3□ DOA this To the Hospitat or Attending Phywithin 24 hours after deeth.
To the Funeral Director: After this completely filled in by the funeral is 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifies 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gles WAShing ton Medica 31. Date filed (Month, Day, Year) NOV 0 8 2006 32. Radistrar's Signatu

State Registrar

Joanna

State of Maryland / Department of Health and Mental Hygiene 2005 35233 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death November 2, **Physician** Michael Hammonds 2006 9:45 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6640 Antelope Court Waldorf Charles If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day Year)
November 7, 1958 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1X M 2□ F 47 MAryland 219-70-0688 Yrs Director Usual Residence of Decedent the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits rithen "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Charles Maryland Waldorf 1 ☐ Yes 2X No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20603 6640 Antelope Court USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □Xes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) other than College (1-4or 5+) Engineer Phone Company 12 years i. Pages 1 end 2 should be filed withen of Health and Mental Hygie risht; if Item 27 is marked other to lury or other traumatic svent, in 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ertly B. Hammonds Elizabeth Lockleer ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) wife 6640 Antelope Court, Waldorf, Maryland Debbie Trusty 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition November 20c. Location - City or Town, State permit. Pages 1
Department of H
importent; if ite
any injury or ot 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 8, 2006 Baltimore City, MD. 22. Name and Address of Facility
Connelly Funeral Home Of Dundalk, P.A. Signature of Tuneral Service Licenses 7110 Sollers Point Road, Dundalk, MD. 23a Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gluse on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Carcinoma of the Lung /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine ysicien end Y The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical ettending physic for use as the b 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death signed by the e 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 3 ☐ Probably 4 [X]Unknown should should 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has t irector, page 2 s autopsy performed? 1□ Yes 2**2** No 1 ☐ Yes 2 ☑ No Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ۵ 1 Yes 2 XNo this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Natural Natural 5 Pending investigation within 24 hours efter death.

To the Funerei Director: All completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge death conumed at the lime, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mardin O, Well to D23743 -2-06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Martin Weltz MD 7525 Greenway Court Drive, Greenbelt, MD. 20770 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygien 2006 35234 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** B. Hood 11 PM Margaret

4a. Facility Name (If not institution, give street and number) -06 02 /Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospital Center Westminster Carrol1 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day Year)
Jan. 7. 1930

9. Birthplace (State or Foreig New Hampshire) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min 179-20-9544 76 Director Usual Residence of Decedent with the Maryland r than "natural", or items 23a or 28a-f ehow the Medical Examinar must be notified at 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No MD Baltimore Reisterstown 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 5309 Glen Falls Road 21136 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after ☐ Yes 2 Yes, Give 1 Never Married 2 Married 2**X** No Baltimore, Maryland 21215-0036 1 Yes 28 No White Specify: Specify: þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry l Hygiene. Carroll County Elementary/Secondary (0-12) College (1-4or 5+) School Teacher Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) is 1 and 2 should be fill Health and Mental H tem 27 is marked of Benjamin Franklin Grace Conklin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Depertment of Health ar Important: If Item 27 is eny injury or other treus George L. Hood Husband 5309 Glen Falls Road, Reisterstown, MD 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 In Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Carroll Cremation 11/7/06 Hampstead, Maryland 22. Name and Address of FacilityEline Funeral Home 21. Signature of Funeral Service Licensee 11824 Reisterstown Road, Reisterstown, MD 21136 cim Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death BRONCHO Immediate Cause (Final disease or condition resulting in death) Physician DAY /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ EM 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificate 1 ☐ Yes 2 1 No Vital Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 Hipatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 BNatural 5 Pending investigation after death. 2 Accident Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the I 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 2006 address of person who completed cause of death (Item 23a) (Type, Print) WAMING-TOOV F 0 224 M). 31. Date filed (Month, Day, Year) State NOV 0 8 2006 Registrar

		•	For State Registrar	State of Marylar		artment of I		nd Mental Hy		21116	35235
	Physici	an	Decedent's Name (First, Middle, Last,	101.14 n	1)	- Incate of	Doain	2. Date of De	Day		3. Time of Death
No.	/Medic	al	4a. Facility Name (If not institution, give	street and number)	レ	4b. City Town,	or Location of	Wovem!	Dev >	2006 County of Death	12:44 7 M
		ŭ.	Mever Medic	1 Cente	-	BAL	-771	noné	1	3al TS	MONE
	Funeral Director		5. Social Security Number 6. Sec. 212 · 74 · 6898	7. Age (In yrs.	last birthday) 50 Yrs.	Months Days		Min. 8. Date of Bi	rth ay, Year) 1950	Cou	place (State or Foreign ntry)
	/land		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation					10d. Inside City Limits
	he Man	ector	MD NA		Baltir	none					1 Yes 2 No
	th with t	Funeral Director	3523 Cliffmont	Avenue		10f. Zip Code	21213	,	10g. Citia	zen of What Cou USA	ntry?
40	Iter dea	Funer	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No	J.S. 13.	Was Decedent of If Yes, specify Cub	Hispanic Orig pan, Mexican,	in? (Specify Yes or No Puerto Rican, etc.)	o- 1	14. Race - Ameri Black, White,	
21215-0036	72 hours after death with the Maryland natural', or Iteme 23a or 28e-f ehow dical Examinar must be notified at	þ	3 Mary Midowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🕱 No			,		ack
215-	within 72 ene. then "nat	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e <i>completed)</i> College (1-4or 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retire	during most	of working	_	nd of Business/In	
	filed wil Hygien other th		12th grade 17. Father's Name (First, Middle, Last)	NJA		CashTe		's Name (First, Middle		permar Sumame)	ket
Maryland	should be filed within and Mental Hygiene. marked other then imatic event, Ine Me	To Be	James Cole				13ab				
	2 6 5 6		19a. Informant's Name/Relationship (T) Charles Howard.	Spe, Print) Son	19b. Mailii	ng Address (Stree Mount	alica.	or Rural Route Numb	SCION	un n	Code) 1223
Baltimore,	ges 1 end it of Health if item 27 or other tr		20a. Method of Disposition 1 Seurial 2 ☐ Cremation 3 ☐ F	lemoval from State	cemetery, crei	osition (Name of matory or other pla	ace)	Date	20c. Lo	cation - City or To	own, State
altim	rtmer rtant njury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens	_ 50	20	Name and Addr	ace of Eacility	113/06			Milb, MD
Ä	Derm Depa Impo eny ic		Mu W.	Sw	A	905 York	L Read	Funeral S Baltimo	reM	D 21212	
	Physician		23a. Part 1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition	ne cause on each line.	IM O	ter the mode of dy	ing, such as c	ardiac or respiratory a	rrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec	-	70 214		· · ·			-/week
	p #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consec	quence of):	1 601	UG (ANCE.	rc_	•	monnes
19	execute n and al-trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec		ENTX	4			4	-I week
8760,	icate be executed physician and s the burial-transit	dlcail	· ·	Gram	Negr	1705	- Ba	clerem	IA	6	/ woolc
Box 6	death certific e attending p ed for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregn		76			2	3d. Date of delive	ery
O. B	the deat y the atte	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 □Live birth 2 □Feta 4 □ Pregnant at time of c 9 □ Unknown		Dectopic pregnance Other (specify)	:у			Month	Day Year
<u>α</u>	res that the de igned by the be detached	by Ph	Part II. Other significant conditions con	ntributing to death but not res	sulting in the u	nderlying cause gr	ven in Part I.	23e. Did	tobacco us	se contribute to t	he cause of death?
Sord	v requir	eted						_ +4		7-	pably 4 □Unknown
Vital Records,	The lav	Completed						24a. Was auto perfo		death?	psy findings available impletion of cause of
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:		1.00		of Death Check only		7.3.03	20.10
o	dis Y	. To	1 Yes 2 No	28a. Date of Injury	ER/Outpatier 28b. Time o	" SLI DOA		sing Home 5 Resi			ý)
ion	Attending r death. sctor: After by the fune	atlor	1 → Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Wo	ork?]Yes 2 □ N		,,	333.133	
Division of	i or Attendation after death	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	iome, farm, str	reet, factory, office		28f. Location (City or To	Street and wn, State)	Number or Rura	al Route Number,
	To the Hospitei or Attending Ph within 24 hours affect death. To the Funeral Director. After completely filled in by the funeral		(Check only 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina	owledge, deall	h occurred at the tr	ime, date and	place, and due to the	Cause(s)	and manner as s	tatou.
	To the Pwithin 2 To the Complete	Medical	one) 29b. Signature and title of certifier	and manner stated.			se number			signed (Month,	
	F 3 F 8		21/2m	n m	7 ,)	1		6			
	,4		30. Name and address of person who co		m 23a) (Type,	Print)	11 10	, 12 -	-7	1112	3,200C
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature,	medi.	- 11	di sul	1 111	10/00,	1807-120 J

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vear **Physician** DOROTHY ANN HOWERTON 1:42 p November 3, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Center Cheverly Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🛛 F Director 84 190-18-0103 Aug. 6, 1922 Pennsylvania Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or iteme 23a or 28a-f ehow the Medical Examinar must be notified at Director 1 ☐ Yes 2 X No Maryland Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5029 Edmonston Road U.S.A. 20781 filed within 72 hours after death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No þ Specify Specify: 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) Landlord 12 Rental Units permit. Pages 1 and 2 should be file Department of Health and Mental Hy important; if item 27 is marked othe any injury or other treumatic event, spag. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Peter Rakocy Maria Zarek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Howerton - Son 4920 Taylor Road, Edmonston, Maryland 20781 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 IX Cremation 3 ☐ Removal from State 4 □Donation 5 □ Other (Specify) Metropolitan Crematory 11/6/2006 Alexandria, Virginia 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Funeral Service Licensee Jas 4739 Baltimore Avenue, Hyattsville, MD 20781 Canslance 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician EAKING /Medical Due to (or as a consequence of): **Examiner** HYPURIC Saventially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner ed by the attending physiclen and deteched for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à cate has been sig. page 2 should b 3 Probably 4 XUnknown Completed 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy this certificate 1 Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death Check only one Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 ▼ No 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation 1 Tes 2 No 2 ☐ Accident within 24 hours efter deat To the Funeral Director: 3 ☐ Suicide 6 Could not be in by t 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physicien: To the best of my knowledge death occurred at the time date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) BD0053703 10 30. Name and address of Jack School completed cause of death (Item 23a) (Type, Print) CHEVERLY MD 20185 TSION DERHANE HOSPITAL 3001 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar NOV 0 8 2006

DHMH 17 Rev 1/2001

ORIGINAL

			T = For State Registrar	State of N	1 arylan		artme	nt of H				gien Reg. No	7111	6	35237
	Physici	an	Decedent's Name (First, Middle, L.		tickli	. 1					2. Date of Dea Month	Da	ıy Y	ear	3. Time of Death
	/Medic	al	Daniel 4a. Facility Name (If not institution, gi			~	4b Cit	Y Town of	Location of	Death	11/05/		c. County of	Death	8:05 P M
7	Examin	er	4728 Shamrock Avenue		'/		40. 01	y, rown, or	Baltim		li tv	4	2. County of	Dealli	
-	Funeral			Sex 7. A		last birthday)		er 1 Year	If Under 2	4 Hrs.	8. Date of Birt (Month, Day	h Vaar	. 9	. Birthp	lace (State or Foreign
L	Director		213 70 4134	1ØM 2□F	49	Yrs.	Month:	s Days	Hours	Min.	08/05/	1957		Cour	Md.
	and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation							1	0d. Inside City Limits
	permit. Pages 1 end 2 should be filed within 72 hours elter death with the Maryland Depertment of Health and Mental Hygiene. Importent: if Item 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other treumatic event, the Madinal Examinar must be notified at ODEs.	tor	Md.]	Baltim	ore City	y					1 X Yes 2 ☐ No
	or 28s	Funeral Director	10e. Street and Number				10f. 2	ip Code				10g. C	itizen of Wh	at Cour	itry?
	23a c	ai	4728 Shamrock Avenue	2				2120					USA		
	tems	unei	11. Marital Status	12. Was Deceder Armed Forces	5?	l.S. 13.	Was Dec If Yes, sp	edent of H ecify Cuba	ispanic Origi n, Mexican,	in? (Spe Puerto I	cify Yes or No- Rican, etc.)		14. Race - Black,		
36	irs efte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 If Yes, Give			1 🗆 Yes	2 No	Specify:				Specify:	В1	ack
Maryland 21215-0036	72 hou	Completed	15. Decedent's E (Specify only highest g	Education		16a. Dece	dent's Us	ual Occup	ation during most	of working	20	16b. h	Kind of Busin	ness/Inc	dustry
215	ithin 7	nple	Elementary/Secondary (0-12)	College (1-40	r 5+)	life.	DO NOT	use retired	di)	or workii	19				
2	ygier her th	ပိ	12 years					velder	10.14-1-1		(5) 14 interes	4.4-1-4-	Vulron	<u> </u>	
and	ntal H ed otl	Be	17. Father's Name (First, Middle, Las	" leus Hicklin					18. Mother		(First, Middle, Sabelle		-		
7	hould Me and Me mark	ဥ	19a. Informant's Name/Relationship			19b. Maili	na Addre	ss (Street	and Number		I Route Numbe			ate. Zip	Codel
Ma	lith and 2 s		Viola J. Crowder / S			1	•	•			more, Ma				,
Baltimore,	s 1 er		20a. Method of Disposition		1 .	Place of Dispo cemetery, crei	osition (N	ame of	ea)	D	ate	20c. L	ocation - Ci	y or To	wn, State
Ë	Page nent cont. If		1 N Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec			ig Memor				1/11/	2006	Rand	allstow	n, M	aryland
a	Deperting mports any inju-		21. Signature of Funeral Service Lice	ensee	'	22				-	ie Funer		CONTRACTOR OF STREET		Market of
_	897.9		P col umenta	your							Baltimor	-	aryland	21	217
	Physician /Medical Examiner		23a. Part1. Enter the disease, or co- shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	y one cause on each	ine.	quence of):					r respiratory ar	rest,			Approximate Interval Between Onset and Death
760,	te be executed ysicien and burial-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a Due to (or a		lue ice of):	phay	peal	Caux	cer					18 months
P.O. Box 68	The law requires thet the death certificat sie hes been signed by the attending phypage 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Feta	al death 3]Ectopic] Other (pregnancy specify)	,				23d. Date of Month		ry Day Year
	w requires the been signed should be de	à	Part II. Other significant conditions Malnourish	1	but not res	sulting in the u	ınderlying	cause giv	en in Part I.						e cause of death? ably 4 Unknown
Il Records,	sicien: The law requ s certificete hes been lirector, page 2 should	Completed											prio dea	r to cor	psy findings available impletion of cause of
/ita	ysicien: is certific director,	Be	25. Was case referred to medical examiner?	Hospital:				Oth			(Check only o				
of Vital	<u>></u> . <u>w</u> 0	2	1 Yes 2 No 27. Manne of Death	1 Inpa		ER/Outpaties 28b. Time o		OOA DUU	4 Nurs		ne 5 Resid			(Specify	()
lo	nding Physath. r: After this e funeral di	ation	1 Natural 5 Pending 2 Accident investigati	(Month, L	Day Year)	Injury	м	28c. Injury Work	k? Yes 2 □ N		.ou. Describe i	10 10 11 11 10	ny occurred		
Division	To the Hospital or Attending Phwithin 24 hours eiter death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Surcide 6 Could not determine	A 200. FIACE OF	njury - At h etc. <i>(Specii</i>	ome, farm, st	reet, facto	ory, office		2	28f. Location (S City or Tox			or Rura	l Route Number,
	Hospi 24 hou. Funer	Medical	29a. Certifier 1 Certifying F (Check only one) 2 Medical Ext	Physician: To the beaminer: On the basis and manner	of examina	owledge, deat ation and/or in	th occurre	d at the tin	ne, date and pinion, death	place, a	and due to the ded at the time,	cause(s	s) and mann id place, and	er as st	ated. the cause(s)
	o the	Me	29b. Signature and title of certifier				2	9c. Licens	e number			29d. Da	ate signed (/	Month,	Day, Year)
	- > - 0		h. austin	, Dayle	ws			D	23809)		N	oveint	en	6,2006
			30. Name and address of person wh	o completed cause of	death (Iter	m 23a) (Type,	Print)				1				
			L. Fresto Days	e, me c	reenels	um C	aurie	- Ctr.	. 22	5, 6	reene 5	トゥ	Britis	0.~e	MD 21201
	Sta Regist		31. Date filed (Month, Day, Year)	JZ. Mygn	strar's Sign	II A	seal.	2			-				

			Please		rint in Black I					
0			1 - State Registrar	State of	Maryland / Dep	partment of i e <i>rtificate of</i>			2000	25220
			Decedent's Name (First, Middle, La	st)		Timeate of		2. Date of Deat	eg. No	3. Time of Death
	Physici /Medio		Walter G	. Jung				Month	mher 7 20	
A.	Examir		4a. Facility Name (If not institution, giv		· ·		or Location of Death		4c. County of De	ath
			Genesis - Loc 5. Social Security Number 6.5				ville		Balti	
	Funeral Director			ex IXDM 2□F	Age (In yrs. last birthda, 9.1 Yrs.	Months Days		8. Date of Birth (Month, Day,		irthplace (State or Foreign Country)
			Usual Residence of Decedent		91			7/18/1	915 M	aryland
_	r 28e-f ahow	_	MD Balti	m e m e	10c. City, Town or					10d. Inside City Limits
Ş	he M	Director		шоте	Carne	_				1 ☐ Yes 2X22No
ζ	妻 2周	급	10e. Street and Number 9629 Harding	Δνο		10f. Zip Code	21234	11	0g. Citizen of What (USA	Country?
	ours after deeth w al', or itema 23a Evantar must	Funerai	11. Marital Status	12. Was Decede	ent Ever in U.S. 13			cifv Yes or No-		nencan Indian.
9		교	1 ☐ Never Married 2 Married	Armed Force 1 Tyes 2 1 Tyes, Give	es? □No	_	Hispanic Origin? (Spectoan, Mexican, Puerto R	lican, etc.)	Black, Wh	
93	72 hours after natural', or its ilgal Exemine	d by	3 Widowed 4 Divorced	Year or Date	98:	1 ☐ Yes 2X No	Specify:		Specify:	White
15-		lete	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Dec	edent's Usual Docu	ipation a during most of workin ad)	9	16b. Kind of Busines	s/Industry
12	ywithii jiene. r than	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)		~ Technici		Bendi	ĸ
þ	filed Hyg other	BeC	17. Father's Name (First, Middle, Last,)		CCIONIC	18. Mother's Name		Maiden Sumame)	
/lar	uid be Vienta Vienta rrked	To B	Walter Jung				Cat	herine	A. Due	cbeck
Maryland 21215-0036	s 1 end 2 should be filed within f Heelth and Mental Hygiene. Item 27 Is marked other than " other traumatic event, I'm Me.	·	19a. Informant's Name/Relationship (t and Number or Rural			
	of Heelth item 27 other tr		Mildred A. Ju	ng - wi			ing Ave.	-		
Baltimore,	m 0		20a. Method of Disposition 1 Burial **Coremation 3 C		20b. Place of Dis cemetery, cr ate Evans F	ematory or other pla uneral	Noxem	ber 2006	Eorost	Hill, MD
튶	permit. Page Depertment important: if any injury o	1	4 □ Donation 5 □ Other (Special 21. Signal of Juneral Service the		Chapel	 Bel A: 22. Name and Addr. 	ir	2000		
Ba	Depe impo any i		16/10/54	11	E	vans Fui	neral Cha	pel	Parkvil	arford Rd. Le, MD ₂₁₂₃₄
1	Physician /Medical Examiner		23a. Part1. Enter the disease, or combook, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a	as a consequence of):	enter the mode of dy		respiratory arre	est,	Approximate Interval Between Onset and Death
68760,	cate be executed physicien and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	as a consequence of):					
P.O. Box 6	certifi ding se as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		h 2 ☐ Fetal death 3 ht at time of death 5	□Ectopic pregnand □ Other (specify)	гу		23d. Date of d Month	elivery Day Year
	ires tha signed d be dei	ed by Pt	Part II. Other significant conditions of	contributing to deal	th but not resulting in the	underlying cause gi	ven in Part I.	1		to the cause of death? Probably 4 Munknown
Division of Vital Records,	The law ete hes b page 2 s	Completed by						24a. Was ar autopsy perform 1 Yes 2	y prior to	
Vita	Physician: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		0.	26. Place of Death	Check only one	9)	
ŏ		. To	1 ☐ Yes 2 ☒ No 27. Manner of Death	28a. Date of	atient 2 ER/Outpati	ent 3 DOA	4 Nursing Hom		nce 6 Other (Sp winjury occurred	ecify)
ion	Attending I r death. ector: After by the funer	ation	1 Natural 5 Pending 2 Accident investigation	(Month,	Day Year) Injury	Wo	ork?]Yes 2 □No		williary occurred	
Divis	ai or Attendi s efter death. hi Director: A ed in by the fu	Certification:	3 Suicide 6 Could not b 4 Homicide determined	286. Place of	Injury - At home, farm, s , etc. (Specify)	treet, factory, office	28	3f. Location (Str. City or Town	eet and Number or I , State)	Rural Route Number,
	To the Hospital or Attent within 24 hours effer death To the Funeral Director: completely filled in by the	edicai	one)	nysician: To the be niner: On the basi and manner	est of my knowledge, de is of examination and/or r stated.	ath occurred at the t nvestigation, in my	ime, date and place, ar opinion, death occurred	nd due to the ca d at the time, da	use(s) and manner a ite and place, and di	as stated. ue to the cause(s)
	To To To Com	Œ	29b. Signature and fittle of certifier	thou Or	my phys.	29c. Licen	se number 3 7 6 42	29	d. Date signed (Mon	7 200 6
8	0		30. Name and address of person who	completed cause	of feath (Ite 23a) (Type	Print)	rles st	(20.	2 salt.	7 200 G Mul 2/204

State Registrar

31. Date filed (Month, Day, Year)
NOV 0 8 2006



		_ For	State of Marylan	•				ental Hyg	giene		
	_	State Registrar		Cer	tificate of	Death			Reg. No.	2006	35239
Physicia /Medic		1. Decedent's Name (First, Middle, Last) Mary Louise	James					2. Date of Dea Nov •	5 ^{Day}	200°6°	3. Time of Death 10:15 p _M
Examin		4a. Facility Name (If not institution, give st 6801 Boston AV			4b. City, Town, Balt	or Location			4c.	County of Death N/A	
Funeral Director		5. Social Security Number 6. Sex 229 – 30 – 1304	м 2 X F 7. Age (<i>In yr</i> s.	last birthday) Yrs.	If Under 1 Yea Months Days		Min. A	B. Date of Birth (Month, Day DIT	29ar)	1928 Cou. V	
pu ,		Usual Residence of Decedent 10a. State 10b. County	10c Cit	y, Town or Lo	cation						10d. Inside City Limits
Manyla f shov	JO.	Md. N/A	133.34	Balti							1 X Yes 2 □ No
with the I	I Director	10e. Street and Number 6801 Boston Av	e.		10f. Zip Code	1222				zen of What Cou	ntry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	2. Was Decedent Ever in U. Armed Forces? 1 ∐Yes 2 X No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 2 No	ban, Mexica	an, Puerto Ri	ify Yes or No- ican, etc.)		14. Race - Ameri Black, White, Specify: Wh.	etc.
nin 72 hou n "natura Medical E	Completed	15. Decedent's Educ (Specify only highest grade	ation completed) College (1-4or 5+)	16a. Deced (Give life. I	dent's Usual Occi kind of work don DO NOT use retir	upation e during mo: ed)	st of working	7	16b. Kir	nd of Business/Ir	dustry
d with giene er tha the I	E O	8 yrs.	Oblicge (1 401 01)	I	Housewi				Но		
uld be file Mental Hy rked othe	To Be (17. Father's Name (First, Middle, Last) Berkley Rice						First, Middle, Rice		Surname)	
and 2 sho ealth and 1 27 is ma er trauma		19a. Informant's Name/Relationship (Type Mary Zedek	e. Print) daughter	19b. Mailir 680	ng Address (Stree					r Town, State, Zi _l e Md .	
Pages 1 ant of He		20a. Method of Disposition 1 🛱 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	emoval from State 20b. F	Place of Dispo cemetery, crei . Sta	sition (Name of matory or other p nislau	lace) S	Nov.	9		cation - City or T Ltimore	
permit. Departm Importa any inju		21. Signature of Foneral Service License		200 7 T	Name and Add Onnelly 110 Sol	resser Facilities lers	eral		Of 21	Dundal 222	k
Physician /Medical Examiner		23a. P 1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the deat e cause on each line. Due to (or as a conseq	ine	er the mode of d		s cardiac or	respiratory ar	rest,	,	Approximate Interval Between Onset and Death
is / de	Examiner	Sequentially list conditions, if any, leading to immediate cause. Litter Unuariying Cause (Disease or injury that initiated events c.									
e be executed sician and burial-transit	dical Exar	resulting in death) Last Due to (or as a consequence of):									
The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transitions.	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ac. If yes, outcome pf pregn: 1 □ Live birth 2 □ Fete 4 □ Pregnant at time of c	al death 3	□Ectopic pregnar □ Other (specify)				2	23d. Date of deliv Month	rery Day Year
uires that t signed by	þ	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying cause (given in Part	: I.		obacco u Yes 2[the cause of death?
ne law require has been signed 2 should k	Completed								rmed?	prior to co	opsy findings available ompletion of cause of
	ပိ	25. Was case referred to medical				26. Plac	ce of Death	1□ Yes (Check only o	2XI No	1 ☐ Yes	2 No
ysicia s cert	0 13	avaminer?	ospital: 1 ☐ Inpatient 2 ☐] ER/Outpatier	nt 3□ DOA C	thor:		14		3 □Other (Spec	ifv)
ig Phys ter this	T:U	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. In			Bd. Describe h			
r Attendir er death. Irector: Af	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At h building, etc. (Special	ome, farm, sti	M 1	Yes 2		3f. Location (S City or Tox	Street and	d Number or Rui)	ral Route Number,
To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director After this certific completely filled in by the funeral director,	edical Cer	(Check only 2 Medical Examil	sician: To the best of my knoner: On the basis of examina								
thin 2 thin 2 the I	Medi	29b. Signature and title of certifier	and manner stated.		29c. Lice	nse number	,		29d. Dat	e signed (Month	, Day, Year)
\ \ \		Mach	w\s_		I						6 2000
14		AARON Clarks	mpleted cause of death (Iter	N.C	bark	St	Post	mne	m	021207	<i>C</i> .
Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	La	K)						

Please Type or Print in Black Indelible Ink

)ante Lamont Jo	1	State of Maryland / Department of Health and Mental Hyg I- For State Certificate of Death	iene Reg	No. 2006 35241
Physicia Medical Examir	n/	1 Desedent's Name (First, Middle, Lagt)	Date of Death Month Doctober 25,	3. Time of Death
wiedlodi Exami		4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	october 25,	4c. County of Death
} 		University Hospital Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8	B. Date of Birth	(MM/DD/YYYY) 9 Birthplace (State or Foreign
Funeral Director		214-15-8497 1 Months Days Hours Min Usual Residence of Decedent		-86 Maryland
s any		10a State 10b. County 10c City, Town or Location		10d Inside City Limits
Maryland 28a-f show	ğ	10e. Street and Number	10a	1 Yes 2 No Citizen of What Country?
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene unt: If item 27 is marked other than "natural", or items 23a or 28a-f sho r other traumatic event, the Medical Examiner must be notified at once.	I Director	1408 MYRTIE AUR Floor 21217		USA
r death wit or items ? must be !	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto Ric		14. Race - American Indian, Black, White, etc.
s after d	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates.		Specify Black
72 hours	eted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+)		6b Kind of Business/Industry
0036 within iner iene eer than	Completed	9th Student		Student
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner	S B	17. Father's Name (First, Middle, Last) 18. Mother's Name (Fi Short	hae t	Faulcon
2121: should be fill and Mental B is marked atic event,	P	19a. Informant's Name/Relationship (Type, Print) (Mollor) 19b. Mailing Address (Street and Number or Rura	al Route Number	er, City or Town, State, Zip Code)
ore, MD sstand 2 sho of Health and If item 27 is		Shorthe Faul CON 1408 M9RHe Ave. 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, D		20c. Location - City or Town, State
Baltimore, permit Pages I an Department of Hes Important: If iter		1 X Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: TFiniti Comp to rul 11-2	-06	Baltimore, MD
Baltimo permit Pag Department Important: injnry or ot	ı		e Fun	eral Services
Physician	\dashv	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or re	20 20	t, shock, or heart Approximate Interval
/Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Gunshot Wounds		Between Onset and Death
		or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of):		
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		
d sit	Examiner	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):		
executed an and al - trans		d. UNPENDED AMENDED		
760, cate be physici he buri.		IF FEMALE. 23c. If yes, outcome of pregnancy		23d Date of delivery
x 68	sician/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (Specify)	/	Month Day Year
Division of Vital Records, P.O. Box 687 ral or Attending Physician: The law requires that the death certific irs after death. al Director: After this certificate has been signed by the attending pled in by the funeral director, page 2, should be detached for use as the content of the detached for use as the content of the detached for use as the content of the content of the detached for use as the content of the content	Physi	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e Did tobs	acco use contribute to the cause of death?
P.O es that t	2	Part in. Other significant continuous Continuous to dearn but not resulting in the underlying cause given in rail in		2 No 3 Probably 4 Unknown
rds, require been sishould be	letec		24a Was an autopsy	
Reco The law cate has	Completed		perform 1 Yes 2	
ital Fician:	Be	25 Was case referred to medical examiner? Hospital: 1 Inpatient 2 Re/Outpatient 3 DOA Other Nursing H		esidence 6 Other:
of V ig Phys fter this	٩	1 V Yes 2 No 27 Manner of Death 28a Date of Injury 28b. Time of Injury 28c. Injury at Work? 28	id Describe ho	w injury occurred
sion ttendin death etor: A y the fu	ation	2 Accident Investigation	ıbject shot	
Divisior al or Attend as after death at Director:	Certification:	Suicide 6 Could not be determined (Specify) Street	or Town, Star	eet and Number or Rural Route Number, City te) lds Place, Baltimore, MD
Hospi 24 hou Funer tely fil	Medical Ce	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the	e to the cause(s) and manner as started
To the within To the comple	Mec	and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed (Month, Day, Year)
		O.C.M.E.		October 28, 2006
7		30 Name and Address of person who completed cause of death (Item 23a) Mary G Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD	21201	
	ate	31 Date filed (Month, Day, Year) 32 Registrar's Signature		
Regis	trar	NOV 0 8 2008 Bloom B. Sypteme		

		•	For State Ragistrar		partment of Health and Pertificate of Death	Mental Hygie	ZUUb	35241
	Physicia	an	1. Decedent's Name (First, Middle, Last)	Ē	Tohnson	Date of Death Month	Day Year	3. Time of Death 1:53 PM
	/Medio		4a. Facility Name (Kinot institution, give,s	strpet and number)	4b. City, Town, of Location of Dea		∠00 6 4c. County of Deatl	
			2408 Draid +	till Avenue	Baltimore			
	Funeral Director		5. Sócial Security Number 216-30-0609 Usual Residence of Decedent	M 2 F 7. Age (In yrs. last birthd	Months Days Hours Min		9. Birth	nplace (State or Foreign untry)
	yland		10a. State 10b. County	10c. City, Town of	r Location			10d. Inside City Limits
	Sa-f el	etor	MD	Balt	more			1 XYes 2 □ No
	be filed within 72 hours after deeth with the Maryland nat lygiene. do other then "naturel", or items 23a or 28s-f show event, I've Medical Examical must be codified at	Funeral Director	2408 Druid H	ill Avenue	10f. Zip Code 21217	10g	Citizen of What Co	untry?
	items items	une	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puer 	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White	
036	rel', or	þ	3 Widowed 4 Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 🕱 No Specify:		Specify: B	lack
215-0036	n 72 h "natu edicel	Completed	15. Decedent's Educ (Specify only highest grade	e completed) (G	ecedent's Usual Occupation give kind of work done during most of wo fe. DO NOT use retired)	orking 16	b. Kind of Business/	ndustry
2	filed withi Hygiene. Ither then	Som C	Elementary/Secondary (0-12)	College (1-4or 5+)	lusician	E	nterta	inment
Maryland	should be filed within and Mental Hygiene. Thanked other then imatic event, the M	Be	17. Father's Name (First, Middle, Last)	h C 1 0	18. Mother's Na	me (First, Middle, Ma	iden Sumame) Ur	IK
aryli	should nd Men marke umatic	To	19a. Informant's Name/Relationship (Tyr	nh Son pe, Print) 19b. M	lailing Ad ress (Strat and Number of R	ural Route N, mber, C	ity or Ti wn, State, Z	ip Code)
	s 1 end 2 should f Health and Mer item 27 is marke other treumatic		Sardoro R. Johns			Linthicu		D21090
more,	Pages 1 enement of Hearnint: if item		20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ R	Removal from State	isposition (Name of compatory or other place)		c. Location - City or	1
a	permit. Pages Depertment of Importent: if i eny injury or one.		4 □ Donation 5 □ Other (Specify) 21. Signatur of Funeral Service License		28. Name and sourcess of Facilities		Noodlan	ruces
	89 = 8		Vaughn (.	Spere	8728 Liberty Re	1 1 0 10-10-		D2133
	Physician		23a. Part1. Enter the disease, or complishock, or learn ailure. List only on Immediate Cause (Final	ne cause on each line.	enter the mode of dying, such as cardial streets. Disease			Approximate Interval Between Onset and Death
1	/Medical		disease or condition resulting in death)	Due to (or as a consequence of):	· · · · · · · · · · · · · · · · · · ·			Lyears
	Examiner	- E	Sequentially list conditions,	Due to for as a consequence of):	. Kenal Disca	PC		6 years
V	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to atmediate cause. Enter Underlying Cause (Disease or injury that initiated events	1.37				
8760,	sete be executed thysicien and the burial-transit	al Ex	resulting in death) Last	Due to (or as a consequence of):				
9	ificete g physi as the I	edicai		1.				
Вох	leath certific attending pl	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 Ectopic pregnancy		23d. Date of deli	
P.O.	y the at	Physician/Me	1 Yes 2 No	4☐Pregnant at time of death 9☐ Unknown	5 Other (specify)		Month	Day Year
	- 5 2							
Ś	gned go de		Part II. Other significant conditions cor			23e. Did tobac	cco use contribute to	the cause of death?
ords,	requires the been signed should be de	by			a underlying cause given in Part I.	1 ☐ Yes	2 □ No 3 × Pro	obably 4 Unknown
Records,	he law requires thet the de e has been signed by the a age 2 should be detached	by	Part II. Other significant conditions cor			1 ☐ Yes 24a. Was an autopsy performe	2 No 3 Pro	obably 4 Unknown topsy findings available ompletion of cause of
ital Records,	ilen: The law requires the prilicete has been signed ctor, page 2 should be de	e Completed by	Part II. Other significant conditions cor Hyperlens i on 25. Was case referred to medical		ype 2	1 ☐ Yes 24a. Was an autopsy performe	2 No 3 Pro	obably 4 Unknown
of Vital Records,	Physicien: The law requires the this certificate has been signed al director, page 2 should be de	To Be Completed by	Part II. Other significant conditions con Hypertension 25. Was case referred to medical examiner? 1 Part II. Other significant conditions con 1 Part II. Other significant conditions con 1 Part II. Other significant conditions con 1 Part II. Other significant conditions con 1 Part II. Other significant conditions con	Olabetes 1	26. Place of De atient 3 DOA Cther: 4 Nursing	1 Yes 24a. Was an autopsy performe 1 Yes 2 24ath Check only one) Home 5 Residence	2 No 3 Production of the control of	topsy findings available ompletion of cause of
ion of Vital Records,	nding Physicien: The law requires the th.	To Be Completed by	Part II. Other significant conditions con Hyperlens ion 25. Was case referred to medical examiner? 12 Yes 2 No 27. Mahner of Death 12 Natural 5 Pending), Diabetes	26. Place of De atient 3 DOA Cther: 4 Nursing	1 Yes 24a. Was an autopsy performe 1 Yes 2	2 No 3 Production of the control of	topsy findings available ompletion of cause of
Division of Vital Records,	iing Physicien: The lar i. After this certificete has funeral director, page 2	To Be Completed by	25. Was case referred to medical examiner? 27. Mahner of Death	Diabetes Hospital: 1 Inpatient 2 EP/Outpa 28a. Date of Injury 28b. Tim	26. Place of De atient 3 DOA Other: 4 Nursing lee of large work? M 28c. Injury at Work? M 1 Yes 2 No	24a. Was an autopsy performe 1 Yes 2 American Properties 2 America	2 No 3 Production of the stand Number of Rules	obably 4 Unknown topsy findings available ompletion of cause of 2 No
Division of Vital Records,	Hospital or Attending Physicien: The law requires the 14 hours after deeth. Funeral Director: After this certificate has been signed tely filled in by the funeral director, page 2 should be de	Certification: To Be Completed by	25. Was case referred to medical examiner? 27. Mahner of Death 27. Natural 5 Pending investigation 3 Suicide 4 Homicide 29a. Certifier Check only 2 Medical Examined	Diabetes Hospital: 1 Inpatient 2 ER/Outpa 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home, farm building, etc. (Specify) sician: To the best of my knowledge, diner: On the basis of examination and/o	26. Place of De atient 3 DOA Cther: 4 Nursing the of Work? M 28c. Injury at Work? M 1 Yes 2 No (eath occurred at the time, date and place)	24a. Was an autopsy performe 1 Ves 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	2 No 3 Pro 24b. Were au prior to death? No 1 Yes the 6 Other (Specinjury occurred at and Number or Russiale)	topsy findings available ompletion of cause of 2 No
Division of Vital Records,	To the Hospital or Attending Physicien: The law requires the within 24 hours after deeth. for the Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be de	To Be Completed by	25. Was case referred to medical examiner? 10 Yes 2 No 27. Mahner of Death 12 Natural sinvestigation 2 Accident investigation 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature end till of certifier	Diabetes Hospital: 1 Inpatient 2 ER/Outpa 28a. Date of Injury (Month, Day Year) 28b. Place of Injury - At home, farm building, etc. (Specify) sician: To the best of my knowledge, daner: On the basis of examination and/or and manner stated.	26. Place of De atient 3 DOA Other: 4 Nursing Ne of Work? M 1 Yes 2 No death occurred at the time, date and place or investigation, in my opinion, death occurred at the time, date not place or investigation, in my opinion, death occurred at the time, date and place or investigation, in my opinion, death occurred at the time, date and place or investigation, in my opinion, death occurred at the time, date and place or investigation, in my opinion, death occurred at the time, date and place or investigation.	24a. Was an autopsy performe 1 Ves 2 ath Check on one Home 5 Residence 28d. Describe how 28f. Location (Stree City or Town, 5	2 No 3 Pro 24b. Were au prior to death? No 1 Yes 2e 6 Other (Specinjury occurred at and Number or Russiate) Se(s) and manner as and place, and due	topsy findings available ompletion of cause of 2 No sify) ral Route Number, stated. to the cause(s)
Division of Vital Records,	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical Certification: To Be Completed by	25. Was case referred to medical examiner? 10 Yes 2 No 27. Mahner of Death 12 Natural sinvestigation 2 Accident investigation 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature end till of certifier	Diabetes Hospital: 1 Inpatient 2 ER/Outpa 28a. Date of Injury (Month, Day Year) 28b. Place of Injury - At home, farm building, etc. (Specify) sician: To the best of my knowledge, daner: On the basis of examination and/or and manner stated.	26. Place of De atient 3 DOA Other: 4 Nursing Ne of Work? M 1 Yes 2 No death occurred at the time, date and place or investigation, in my opinion, death occurred at the time, date not place or investigation, in my opinion, death occurred at the time, date and place or investigation, in my opinion, death occurred at the time, date and place or investigation, in my opinion, death occurred at the time, date and place or investigation, in my opinion, death occurred at the time, date and place or investigation.	24a. Was an autopsy performe 1 Ves 2 ath Check on one Home 5 Residence 28d. Describe how 28f. Location (Stree City or Town, 5	2 No 3 Pro 24b. Were au prior to death? No 1 Yes 2e 6 Other (Specinjury occurred at and Number or Russiate) Se(s) and manner as and place, and due	topsy findings available ompletion of cause of 2 No sify) ral Route Number, stated. to the cause(s)
Division of Vital Records,	To the Hospital or Attending Physicien: The law requires the within 24 hours after deeth. To the Funeral Director: After this certificete has been signed completely filled in by the funeral director, page 2 should be de	edical Certification: To Be Completed by	25. Was case referred to medical examiner? 10 Yes 2 No 27. Mahner of Death 12 Natural sinvestigation 2 Accident investigation 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature end till of certifier	Diabetes Hospital: 1 Inpatient 2 ER/Outpa 28a. Date of Injury (Month, Day Year) 28b. Place of Injury - At home, farm building, etc. (Specify) sician: To the best of my knowledge, daner: On the basis of examination and/or and manner stated.	26. Place of De atient 3 DOA Other: 4 Nursing Ne of Work? M 1 Yes 2 No death occurred at the time, date and place or investigation, in my opinion, death occurred at the time, date not place or investigation, in my opinion, death occurred at the time, date and place or investigation, in my opinion, death occurred at the time, date and place or investigation, in my opinion, death occurred at the time, date and place or investigation, in my opinion, death occurred at the time, date and place or investigation.	24a. Was an autopsy performe 1 Ves 2 ath Check on one Home 5 Residence 28d. Describe how 28f. Location (Stree City or Town, 5	2 No 3 Pro 24b. Were au prior to death? No 1 Yes 2e 6 Other (Specinjury occurred at and Number or Russiate) Se(s) and manner as and place, and due	topsy findings available ompletion of cause of 2 No sify) ral Route Number, stated. to the cause(s)
Mivision of Vital Records,	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical Certification: To Be Completed by	25. Was case referred to medical examiner? 1. Vest 2 No 27. Mahner of Death 1. Vatural 5 Pending investigation 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier 0. Name ss of person who come of the control of the control of the control of the certifier 1. Vatural 5 Pending investigation of certifier 29a. Certifier (Check only one) 29b. Signature and title of certifier 1. Vatural of certifier 29b. Signature and title of certifier 31. Date filed (Month, Day, Year)	Diabetes Hospital: 1 Inpatient 2 ER/Outpa 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home, farm building, etc. (Specify) sician: To the best of my knowledge, diner: On the basis of examination and/o	26. Place of De atient 3 DOA Other: 4 Nursing Ne of Work? M 1 Yes 2 No death occurred at the time, date and place or investigation, in my opinion, death occurred at the time, date not place or investigation, in my opinion, death occurred at the time, date and place or investigation, in my opinion, death occurred at the time, date and place or investigation, in my opinion, death occurred at the time, date and place or investigation, in my opinion, death occurred at the time, date and place or investigation.	24a. Was an autopsy performe 1 Ves 2 ath Check on one Home 5 Residence 28d. Describe how 28f. Location (Stree City or Town, 5	2 No 3 Pro 24b. Were au prior to death? No 1 Yes 2e 6 Other (Specinjury occurred at and Number or Russiate) Se(s) and manner as and place, and due	topsy findings available ompletion of cause of 2 No sify) ral Route Number, stated. to the cause(s)

ELMER CHARLES JARUSEK

NAME KNOWN TO PHYSICIAN:

		1 - For Stata Registrar	Oldie Ol IV	iai yia	ind / Depa <i>Cei</i>			neaith Death			gien Rea. N	20	NE	3521.
Physici	200	1. Decedent's Name (First, Middle, L	ast)			-				2. Date of Dea	ath		00	3. Time of Death
/Medic		Elmer Charles Ja								NOVEMBE		ay 2	OO6	3:56 A.
Examin	er	4a. Facility Name (If not institution, g		,		4b. City	Town, o	r Location			4	c. Coun	ty of Death	
uneral		VA MARYLAND HEAD 5. Social Security Number 6.			M s. last birthday).	If Unde	1 Year	PERI If Under	RY PO			CECIL		
irector		220-18-7653	X M 2□ F	80	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day			1	place (State or Foreigntry)
2		Usual Residence of Decedent								Jan. 9,		126	Mary	Land
aho	ō.	10a. State 10b. County		10c. C	City, Town or Lo	cation								10d. Inside City Limit
r 28e-f ahow notified at	Director	Maryland Harfo	ord		Abingdo	10f. Zir	Code				10- 0			1 ☐ Yes 2XX N
0 3	Ö	1413 Pomeroy Ave	muo			101. 21		.00			rog. C		What Cou	ntry?
E U	Funerai	t 1. Marital Status	12. Was Deceden Armed Forces	Everin	U.S. 13. V	Vas Dece	210 dent of H		gin? (Spe	ecify Yes or No- Rican, etc.)		USA 14. Ra	ce - Americ	can Indian,
100	y Fu	1 Never Married 2 Married	1 XYes 2	No		Yes, spe		in, Mexicar Specify:		Hican, etc.)			ack, White,	etc.
al Ex	ed by	3 Widowed 4 Divorced	Year or Dates:	WWI:	I .							Speci	Wh	ite
ondical Ex	Completed	15. Decedent's E (Specify onty highest gi	ade completed)		16a. Deced	lent's Usu kind of wo DO NOT u	nk done d	<i>during</i> mas	t of worki	ng	16b. F	Kind of E	Business/In	dustry
The My	mo	Elementary/Secondary (0-12)	Cotlege (1-4or	5+)	Cheif						rr c	C.		ara e
vent	Bec	17. Father's Name (First, Middle, Las				OL	oupp		r's Name	(First, Middle,	Maidei	Sumai	overnr	nent
atic	2	Francis Elmer Ja						Hel	ena	(nmn) P	ach	olil	<	
raumatic event, In		19a. Informant's Name/Relationship						and Numbe	r or Rura	I Route Number	r, City	or Town	, State, Zip	
Important: if item 27 is marked othe any injury or other traumatic event, once.		Lilo M. Jarusek/ 20a. Method of Disposition	Wife	205	1413	Pome	roy.	Avenu		bingdon				
0.0		1 Burial 2 ☐ Cremation 3	Removal from State		Place of Dispos cemetery, crem			ı			20c. L	ocation	- City or To	own, State
injury		4 □ Donation 5 □ Other (Special Signatury of Funeral Service Lice		Mt	Zion						Bel	Aiı	, Mai	ryland
any ir		Mush, 11	Hurch							e, P. A			120	. 01000
		23a. Part1. Enter the disease, or comshock, or heart failure. List only	plication that cause	d the dea	ith. Do not ente	r the mod	of dying	such as	cardiac o	Abingdor respiratory arm	OII,	Man	ryrand	Approximate
hysicie he bu	dicai Examiner	disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as Due to (or as Due to (or as	a conse	quence of):	STATE OF T	<u>IA</u>							UNKNOWN
attending p	IF FEMALE: 23b. Was decedent pregnant: 23c. If yes, outcome of pregnancy													
tached for u	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 4 Pregnant al	2 Feta	aldeath 3⊡€	Ectopic pro Other (spe							te of delive anth	ny Day Year
eq .	2	Part II. Other significant conditions of	ontributing to death b	ut not res	sulting in the und	derlying ca	use givei	n in Part I.		23e. Did tob			nbute to the	e cause of death?
2 shoul	Completed									24a. Was ar	`	24h 1	Wara auton	osy findings available
page	E									autopsy perform	/ ned?		prior to com death?	npletion of cause of
ō		25. Was case referred to medical examiner?						26. Place	of Death	Check on one	XXVo		1 □ Yes	2 L No
E D	0	1 ☐ Yes 2 No			ER/Outpatient	3 🗆 DO				e 5 ☐ Reside		5 □Oth	er (Specify)
funera	ertification:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	Year)	28b. Time of Injury	28	c. Injury			8d. Describe ho				,
the i	icat	2 Accident investigation 3 Suicide 6 Could not be				М		es 2□N						
filled in by the	ert	4 Homicide determined	28e. Place of Inju- building, etc	Specil	ome, farm, stree fy)	t, factory,	office		21	 Bf. Location (Str. City or Town, 	eet an State	d Numb)	er or Rural	Route Number,
etely filled	edical	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exan	ysician: To the best of the basis of and manner sta	Draillilla	owledge, death outline	occurred a	t the time	, date and nion, death	place, ar	nd due to the cal	use(s) te and	and ma	nner as sta	ited. the cause(s)
completely		29b. Signature and title of certifier				29c.	License	number		29	d. Dat	e signed	i (Month, D	Dav. Year)
		1 Ma	7				1	D5273	9					2006
1	:	30. Name and address of person who	completed cause of d	eath (Iten	n 23a) (Type, Pi	rint)	•		-	Line.	TAO	v ratate	THE **	2000
Κ,		SURESH SHANDELYA,	M.D., VA	MARY	LAND HE	ALTH	CARI	E SYS	TEM,	PERRY I	2011	NT ,	MD 21	.902
		31. Date filed (Month, Day, Year)	32. R⊣ 35 ra								_			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician Month Lester Vernon Jones /Medical November 2006 2:20 P 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner TOWSON If Under 1 Year | If Under 24 Hrs. Hoothe Days Hours Min. Gilchrist Center @ GBMC Baltimore Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1X M 2□ F Director 215-28-2434 74 Oct. 18, 1932 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Bel Air Maryland Harford 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 504 B Lloyd Place 21014 USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ★ Married 2 No altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7. th and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Owner/Operator Law Office 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ۵ Charles Elmer Jones <u>Nellie Augusta Schreiber</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sr Department of Health and Important: If Item 27 is n any Injury or other traun once. Shirley L. Jones/ Wife 504 B Lloyd Place, Bel Air, Maryland 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Hilltop Service Corp 11-06-06 Towson, Maryland 21. Signatur / Funeral Service License ²McComas Funeial Home, P. A. tefle 1317 Cokesbury Rd., Abingdon, Maryland 21009 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician months disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed burial-transit and) Due to (or as a consequence of): Box 68760, physician the attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) P.O. cate has been signed by the page 2 should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an performed certificate 2 No Hospital or Attending Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Hother (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပို 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 3, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

6701

N. Charles St. Balts, md 2,20x

			1 - For State Registrar	State of Ma		epartment o Certificate o		nd Mental	Hygiene Reg. No	2000	35244	
	Physici	an	1. Decedent's Name (First, Middle, Last) Mildred E.	Vomo				2. Date of Death Month Day Year November 7 2006 01				
	/Medic Examin		4a. Facility Name (If not institution, give s GREATER BALTIMORI	Death								
	Funeral Director		5. Social Security Number 212-76-2335 6. Sex 1 □ M 2 □ F 98 Yrs. 1 □ If Und Months				ear If Under 2 ays Hours		i, Day, Year)	ay, Year) Country)		
	/land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				1	0d. Inside City Limits	
	e Man	ctor	Maryland Baltimor	e Co.		Cockeys	sville				1 🗆 Yes 🔀 No	
	ith with th	ai Dire	300 International	Circle		10f. Zip Coo	^{de} 2103	0	10g. Citi	;. Citizen of What Country? USA		
980	72 hours after death with the Maryland Insture!' or Items 23a or 28s-f show dical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	I2. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	ver in U.S.	13. Was Decedent If Yes, specify (in? (Specify Yes o Puerto Rican, etc		14. Race - Americ Black, White, Specify:Whit	etc.	
21215-0036	C 2.3	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ecedent's Usual Oc Give kind of work do fe. DO NOT use re Memaker	ccupation one during most atired)	of working	16b. Kir	Own Home				
73	filed withing Hygiene.	Be Co	17. Father's Name (First, Middle, Last)	1			18. Mother	's Name (First, Mi	ddle, Maiden			
aryland	2 should be and Mental I is marked or eumatic eve	ToB	Charles Upton Shu	man				ora Eliz				
Var	12 should h and Men 7 is marke treumatic		19a. Informant's Name/Relationship (Type Charles F. Kemp			failing Address (St						
ē,	s 1 and 2 should of Health and Mer item 27 is marke other treumatic		20a. Method of Disposition	son		5 Linton isposition (Name of crematory or other		Date		y⊥ano ∠i cation - City or To		
DO I	Pages nent of ent: If it iry or o		1√Burial 2 Cremation 3 □R 4 □Donation 5 □ Other (Specify)	emoval from State				1/10/200	Balt:	imore. M	arvland	
20a. Method of Disposition St. Mary St.												
	Physician /Medical		23a Part 1. Enter the disease or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused in a caused line.	the death. Do no	enter the mode of	dying, such as c	ardiac or respirato	ory arrest,		Approximate Interval Between Onset and Death	
	Examiner	licai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Dissess or injury that initiated events resulting in death) Last	Due to (or as a	consequence of consequence of consequence of	te he fik	uilal	failu	ne		home	
P.O. Box 6	Attending Physician: The law requires that the death certificate be executed to death. A chastl. A chastl. A chastl. A chastl. A chastl. A chastl. A chastl. A chastle this certificate has been signed by the ettending physician and the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 2 No 9 □ Unknown	3 ☐ Ectopic pregni 5 ☐ Other (specify			_ 2	23d. Date of delive Month	ery Day Year			
Vital Records, P	luires that n signed b ild be deta	۵	Part II. Other significant conditions con	tributing to death bu	t not resulting in t	ne underlying cause	e given in Part I.		Did tobacco u:		ne cause of death?	
ooa	law requir as been si 2 should	Completed	h	one -					Was an	24b. Were auto	psy findings available mpletion of cause of	
Œ Œ	: The la	Com							performed?	death? 1 ☐ Yes	_	
Vita	sician: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	ospital:			Other	of Death (Check o				
ion of	nding Phys ath. r: After this e funeral di	ation; To	1 Yes 2 No 27. Manner of Death 1 Novatural 5 Pending 2 Accident investigation	t Inpatier 28a. Date of Injury (Month, Day		ne of 28c. I	4 Nurs Injury at Work? 1 Yes 2 N		Residence 6		y)	
Division	tal or Attendi s after death. el Director; A ed in by the fu	Certification	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injurbuilding, etc.	ry - At home, farm (Specify)	, street, factory, off	fice	28f. Locati City o	on (Street and Town, State)	d Number or Rura	il Route Number,	
	To the Hospital or within 24 hours after To the Funerel Direction completely filled in b	Medical (29a. Certifier 1 Certifying Phys	er: Un the basis of	examination and/	leath occurred at their investigation, in r	ne time, date and my opinion, death	place, and due to n occurred at the t	the cause(s) me, date and	and manner as si place, and due to	tated. the cause(s)	
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner stat	9 d.		cense number			e signed (Month,		
	->-0		- Allajan	i M	٩٠	b	0061	519	1	1/07/4	06	
	h	1	30. Name and address of person who co	mpleted cause of de	ath (Item 23a) (Ty	pe, Print)				7 . 7	06 , mo 21117	
	Sta	10	31. Date filed (Month, Day, Year)	JANI 32. Registra	r's Signature		te1947	SRD, C	WIN4:	S, MILLS	, mo 21117	
	Sta Registr		NOV 0 8 20	06	w B	Losel)	1					

		•	For State		State of Ma	iryland /	Depa	artment of H <i>rtificate of l</i>	lealth and	Menta			35245
			Registrar Decedent's Name (First, Mid	ldle, Las	it)		Cel	Tillicate of t	Jealii	2. Date	Reg. of Death	No.	3. Time of Death
	Physicia		Chester W	. K-	irk					Mor	nth ember	Day Year 4, 2006	11:14P M
	/Medic Examin		4a. Facility Name (If not institut					4b. City, Town, or	Location of Dea			4c. County of Dea	
			Montgomery G					01ney		,		Montgom	
	Funeral		5. Social Security Number	6. Se	ex 7. Age	(In yrs. last t	b <i>irthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	1. (Moi	of Birth oth, Day, Ye	9. Bir	thplace (State or Foreign ountry)
	Director		394-32-9240 Usual Residence of Decedent			70				рес	. 27,	1935 Wis	consin
	nyland how		10a. State 10b. Cour	nty		10c. City, To	wn or Lo	ocation					10d. Inside City Limits
	8a-1 s	Director	Maryland Mont	gome	ery	01ne	у						1 ☐ Yes 2 X No
	with the	Dire	10e. Street and Number	_				10f. Zip Code				Citizen of What C	
	72 hours after deeth with the Maryland natural', or Itema 23a or 28a-f ahow Lical Examinat coust be motified at	Funerai	17428 Cherokee	Lar	12. Was Decedent E	ver in U.S.	13	20832	isnanic Origin? (Specify Ver		ited Sta	
0	r iter diner	Fun	1 ☐ Never Married 2 ☑ M	arried	Armed Forces? 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		_	Was Decedent of Hi If Yes, specify Cuba		rto Rican, e	itc.)	Black, Whi	
3-003p	rat', o	å by	3 Widowed 4 Divorc	ed	If Yes, Give Year or Dates:	1958		1 ☐ Yes 2 🖾 No	Specify:			Specify: W	hite
2	72 h	etec	15. Deced (Specify only high	ent's Ed	lucation de completed)	16	(Give	dent's Usual Occupa	during most of wo	orking		. Kind of Business	•
7	within	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)		<i>DO NOT u</i> se retired, nister)		U	Inited Me Chur	
7	filed Hygid other	မ ပိ	17. Father's Name (First, Middle	e, Last)			***	HISCEL	18. Mother's Na	ame (First, i	Middle, Maid		CII
and	lid be hental rked c	ToB	Raymond R.	Kiı	rk				0ri11:	a Bai	ley		
Mary	and N		19a. Informant's Name/Relatio	nship (7	Type, Print)	19	9b. Mailir	ng Address (Street a	and Number or F	Rural Route	Number, Ci	ty or Town, State,	Zip Code)
e, ≧	and 2 ealth m 27 I		Edith M. Kirk	/Wif	f e			8 Cheroke	e Lane,				0832
9	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Hygiene. Department of the return and the word, the Medical Examiner dust be notified at any injury or other traumatic avant, the Medical Examiner dust be notified at any injury.		20a. Method of Disposition 1 ☐ Burial 2 🎇 Crematio			20b. Place cemel	of Dispo tery, crer	osition (Name of matory or other place CY	e) Nove	Date	8 200	. Location - City or	Town, State
Бант	it. Par rtmen rtant: njury		4 ☐ Donation 5 ☐ Other 21. Signature Numeral Servin		A	Crema	tori	um. Inc.	12006	ember	β _Δ Β _α	ethesda,	Maryland
ď	Depa Depa Impo any i		I Signature William Serve	5,	Buy.	400803	B B	ethesda-C ethesda,	hevy Marvlan	ase, 1	Inc. 7	557 Wisc	uneral Home/ onsin Avenue
			23a. Part1. Enter the disease, shock, or heart failure. L.	or comp	lications that caused	the death. De					atory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	885	, C.SI	OV (di	NOON					Onset and Death
	/Medical Examiner		resulting in death)		Due to (or as a	consequenc	e ol):						
		- G	Sequentially list conditions,		b. Due to (or se :	E CONTRACTOR	e of):						
	ansit	Examiner	cause (Disease or injury that initiated events	1	Due to (or se's coneaquence of):								
Ž,	ificate be executed physicien and st the burial-transit	Exa	resulting in death) Last		Due to (or as a	consequenc	e of):						-
09/90	ohysic the bu	edical			d								
×	ding 88 8	/Me	IF FEMALE:		23c. If yes, outcome	of pregnancy						201.0	
000	atter for L	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No		1 ☐ Live birth : 4 ☐ Pregnant at	2 ☐ Fetal dea		Ectopic pregnancy Other (specify)				23d. Date of de Month	Day Year
	t the di by the ached	hysi	9 Unknown		9□ Unknown								
S,	v requires thet the de been signed by the should be detached	by P	Part II. Other significant cond	itions co	ontnbuting to death bu	t not resulting	in the u	nderlying cause give	en in Part I.	23€	. Did tobaco	co use contribute to	o the cause of death?
Ö	w require been sl		*****								1 🗌 Yes	2 □ No 3 □ P	robably 4 nknown
o Second	has b	Completed								24a	. Was an autopsy	_ prior to	utopsy findings available completion of cause of
	sician: The law certificate has t rector, page 2 s										Yes 2	death? No 1 ☐ Yes	200 No
=	sicial certil irecto	o Be	25. Was case referred to medi examiner? 1 Yes 2 No		Hospital:	nt 2□ER/0	Duta at	othe Othe	26. Place of De			- C0:: .:	
ō	g Phy er this erat d	\vdash	27. Mann of Death		28a. Date of Injur	y 28b	. Time of	IL SU DOA	4 Li Nui Sirigi			6 □Other (Spe	ecify)
<u> </u>	ath.	atio	2 1100100111	stigation		rear)	Injury		res 2 □No				
JIVISION	or Atta	Certification:	3 Suicide 6 Cou 4 Homicide dete	d not be mined	28e. Place of Inju building, etc		larm, str	eet, factory, office			ation (Street or Town, St		ural Route Number,
ב	pital o		29a. Certifier	de Obe			1210 ·	. 102-0100	1400 1100 1100	a source	71 (2 11 12 12 12 12		e-services
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director; i	edicai	(Check only 2 Medic	al Exam	ysician: To the best on iner: On the basis of and manner sta	examination a	and/or in	vestigation, in my op	pinion, death occ	curred at the	time, date	and place, and due	stated. e to the cause(s)
	Vithin To th comp	W	29b. Signature and title of centr	ior	. ur			29c. License	number	4	29d.	Date signed (Mont	h, Day, Year)
			▶ IJWW	loy				Da	96319	Do	1	16/05	
1	171		30. Name and andress of person	on who	completed cause of de	ath (Item 23a	(Туре,	Print) MAN	N 1.	410	AL.	100 HI	20137
1	Sta	te.	31. Date liled (Month, Day, Yea		32. Resistra	r's Signature	1641	NUT TVUI	ili m	TVE	OU	MA WI	10000
	Registr		NOV (8 2	006	A	1	ACCEPT R				L	

		E
To the Hospital of Attending Physician: within 24 hours after death.	10 the Hospital of Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	hy: /Me Exa
Funeral Director: After this certifica	To the Funeral Director: After this certificate has been signed by the attending physician and harmonically filled in the tringent director, and 2 should be detached for use as the build branch	sic edi mi

		Please Type or					-		_		
		1 - State o	f Maryland /	-	artment of F <i>tificate of</i> .		/lental Hy	•	0000	25	2 I. C
		1. Decedent's Name (First, Middle, Last)			incate or	Dealit	2. Date of De		2000	3. Time of	Death
Physicia /Medic		Diane Eileen Kraus					Novembe Novembe		2006 Year	7:40	рм
Examin	er	4a. Facility Name (If not institution, give street and number 10 Mallow Hill Road	mber)		4b. City, Town, o Baltimor	r Location of Death e			. County of Deat /A	h	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	rth a <i>y, <u>Y</u>ear)</i>	Co	hplace (State or untry)	Foreign
Director		218-52-2552 The state of Decedent		Yrs.			11/21/1	1956	Mary	Land	
aryland show	7.	10a. State 10b. County Maryland	10c. City, To							10d. Inside Cit	-
r 28a-f	Director	10e. Street and Number			10f. Zip Code			10g. Cit	izen of What Co		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ral D	10 Mallow Hill Road			21229				ed State		
fter dea	Funeral	11. Marital Status 12. Was Dec Armed Fo 1 ☑Never Married 2 ☐ Married 1 ☐ Yes		13. \	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	0-	14. Race - Ame Black, White		
ours a	þ	3 Widowed 4 Divorced If Yes, Give Year or Dates:			I∐Yes 2,72TNo	Specify:			Specify: White		
in 72 h n "natu fedical	Completed	(Specify only highest grade completed)			lent's Usual Occup kind of work done OO NOT use retired	oation during most of world)	king		ind of Business/		
ygiene.	Com	Elementary/Secondary (0-12) College (1-40r 5+)	Owner					oping Bu	siness	
d be flic ental Hy ed oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam Shirley I			· ·		
should and Mer s marke	T ₀	Duncan Lee Kraus 19a. Informant's Name/Relationship (Type. Print)			g Address (Street	and Number or Ru	ral Route Numb	per, City o	or Town, State, 2		
l and 2 Health am 27 is		Ronald Zappacosta/Compani				Road, Ba					
ages 1 ent of H rt: If ite y or ot		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from The Donation 5 □ Other (Specify)	State ceme	etery, cren	sition (<i>Name of</i> natory or other plac Ge Cemet e		Date 1 / 2006		timore,		nd.
permit. F Departme Importan any Injur		21 Signature of Funeral Service Sicensee		22	. Name and Addre	ss of FacilityHub	bard Fu	nera	1 Home,	Inc.	
S S E E E		Will Bride	and the death .			ens Avenu			e, Mary		
Physician		23a. Part1. Deter the disease, or complications that of shock, or heart failure. List only one cause on eliminediate Cause (Final disease or condition	TASTATIC	o not ent	OLAL)	CANCER	or respiratory a	arrest,		Approximate Interval Betw Onset and D	veen
/Medical		resulting in death)	(or as a consequence		DEOIO (11000				13101	<u> </u>
LXammer	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	(or as a consequence	ce of):							
e executed ian and unial-transit	Examiner	that initiated events									
be exestician a purial-		resulting in death) Last Due to (or as a consequence of):									
rtificate ng phys as the	Medic	d									
The law requires that the death certificate be the has been signed by the attending physician age 2 should be detached for use as the bur	Physician/Medica	in the past 12 months?	tcome pf pregnancy birth 2 Fetal de	ath 3□	Ectopic pregnancy	<i>y</i>			23d. Date of deli Month		'ear
the deby the a	hysic	1									
ires that the de signed by the a	by	Part II. Other significant conditions contributing to d	eath but not resulting	g in the ur	nderlying cause giv	en in Part I.			use contribute to		eath? Inknown
w requir been si should	Completed	-					24a. Was		1	topsy findings a	
	omb		·				auto		prior to death?	completion of ca 2 ☐ No	use of
Physiclan: The rules certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital:			Oth	26. Place of Dear	th (Check only	one)			
g Phys er this eral dii	n: To	27. Manner of Death 28a. Date		Outpatien b. Time of Injury	1 3 DON	4 LI Nursing H	ome 5 Res 28d. Describe		6 □Other (Spec ry occurred	cify)	
tending Feath. tor: After	catio	2 Accident investigation			M 1 🗆	Yes 2 No					
after d after d Direc d in by	Certification:	determined 200. Flace	e of injury - At home, ing, etc. <i>(Specify)</i>	, farm, stre	eet, factory, office		28f. Location (City or To		nd Number or Ru e)	ral Route Numl	oer,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Medical C	29a. Certifier (Check only one) Certifying Physician: To the back only one)	asis of examination	dge, death and/or in	n occurred at the til	me, date and place opinion, death occu	and due to the	cause(s	and manner as d place, and due	stated. to the cause(s))
To the I within 2 To the I	Med	29b. Signature and title of certifier	iner stated.		29c. Licens	e number		29d. Da	te signed (Montl	n, Day, Year)	
		1 fauls Clorin	by MI	>		1858	+	No	ov 7	2008	9
M		30 Name and address of person who completed cause AUL GORMLEY	se of death (Item 23	a) (Type,	ON AVE	1858 BAI	TIMOR	E	MD	2122	-9
Sta Registr		31. Date filed (Month, Day, Year) 32. F	Registrar's Signature	A	2000						,
			Eller Si	1	20 11 3,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month William John Krasowski 2006 November 12:39 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5229 Benson Avenue Baltimore 8. Date of Birth (Month, Day, Year)
Jan 23, 19 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**X** M 2 □ F 214-82-8354 47 Director 1959 Colorado Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If teem 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatte event, the Medical Examiner must be notified at any Injury or other traumatte event, the Medical Examiner must be notified at MD Baltimore N/A Director 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5229 Benson Avenue 21227 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Electronic Technician Electronics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles William Krasowski Ruth Nellie Linglebach 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy L. Krasowski/Wife 7 Madison Mills Court Catonsville MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Reproval from State
4 □ Donation 5 □ Other (Specify) Loudon Park Cemetery 11-08-2006 Baltimore, Maryland 21. ign; ture of Funeral & 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD 21227 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Asphyxia by **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it is a list of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of be execute burial-trar Due to (or as a consequence of) attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed: 1□ Yes 2□ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2□ No Certification: To this 28d. Describe how injury occurred Suicide by Hanging 27, Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? (Month, Day Year) Injury
November 3,2006 1239 P s after decral Director: After 1 Natural 5 Pending 1 ☐ Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 4 ☐ Homicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5229 Benson Ave Arbutus, Md 21227 filled in by ö Home 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

NOV 0 8 2006

DHMH 17 Rev 1/2001

11/3/2006

MD 6 Trimble H:11 CT. Lutherv:11e, Md 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Phil: > M: | : +e|| a. MD (a Trumble)

Registrar

State

KAPLER

RAYMOND

32. Redistrar's Signature

8 2006

			1- State of Maryland		artment of Health and tificate of Death		2006	35249		
	Physici	20	Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death		
	/Medic		Barbara K. Koawl			November	05 2006	8:10 PM		
	Examin	er	4a. Facility Name (If not institution, give street and number) Cranberry Cottage		4b. City, Town, or Location of Dec Pasaden		4c. County of Death			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. Ia.	st birthday)	If Under 1 Year If Under 24 Hi	S. 8 Date of Birth	Anne Ay	UNGE I lace (State or Foreign try)		
	Director		388-18-5793 1□M 2风F 9		Months Days Hours Mi	July 22	^(ear) 1916 Couin	PA		
	pu ,		Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Lo				0d. Inside City Limits		
	sho	ŏ		TOWIT OF LO			1 Yes 2 No			
	the A 28a-1	rect	Maryland Anne Arundel		Pasadena 10f. Zip Code	10a	. Citizen of What Coun			
	3a or	Funerai Director	54 Magothy Beach Road		2112	_	USA			
	death	nera	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?	. 13. V	Was Decedent of Hispanic Origin? (f Yes, specify Cuban, Mexican, Pue		14. Race - America Black, White, e			
36	or It		1 Never Married 2 Married 1 Yes 2 No		I ☐ Yes 2 ☑ No Specify:	nto i noan, story	Specify: Whi			
Maryland 21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene rd other than "natural", or items 23a or 28a-f show avant, the Medical Examinational temolifical at	ed by	3		dent's Usual Occupation	10	b. Kind of Business/Ind			
15	in 72 n "na	Completed	(Specify only highest grade completed)	(Give	kind of work done during most of w DO NOT use retired)	orking	b. Kind of Businessyllid	lustry		
212	d with	mo:	Elementary/Secondary (0-12) College (1-4or 5+)	C1	erical Worker		Courthouse			
p	al Hy al other	Be (17. Father's Name (First, Middle, Last)		18. Mother's N	ame (First, Middle, Ma.	iden Sumame)			
yla	Ment Ment Marke Marke	P_	Ignatz Kusecak				Unknown			
Nar	12 sh h and 7 ia m traum		19a. Informant's Name/Relationship (Type, Print) Stephen Koawl (son)		g Address <i>(Street and Number or I</i> loan Lane, Pasad			Code)		
آ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Insportment: If item 27 is marked other than "natural; or flems 23a or 28a-f show any injury or other traumatic avant, the Medical Evanting Internal to codifical at once.						c. Location - City or To	wn, State		
altimore,	ages ent of nt: If if		TOGOTIAN 2 DOISHIALION 3 MININOVALINON STATE		v Cemetery		anassan "A			
a E	mit. I partm sortar / inju		21. Signature of Funeral Service Licensor		. Name and Address of Facility		onessen, PA Funeral Ho			
ď	P P E C		and of		3111 Mountain	Road, Pasac	dena, MD 21	122		
			23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause an each line.	Do not ente	er the mode of dying, such as cardi	ac or respiratory arrest		Approximate Interval Between		
-	Physician		Immediate Cause (Final disease or condition	OVE	ascular	accid	ent.	Onset and Death		
	/Medical Examiner		resulting in death) Due to (or as a conseque	nce of):						
		e	Sequentially list conditions, Due to or as a consequence. Enter Underlying							
	uted d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events							
ó	an an rial-tr	Exa	resulting in death) Last Due to (or as a conseque	nce of):						
8760,	cate be executed physician and the burial-transit	dicai	d							
9	ertific ding p	40 +	IF FEMALE:							
Вох	attenc for us	sian	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnant 1 Live birth 2 Fetal d	eath 3	Ectopic pregnancy Other (specify)		23d. Date of deliver Month	ry Day Year		
o.	the d	Physician/M	1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 ☐ Unknown		Carer (Specify)					
<u>a</u>	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	by Pł	Part II. Other significant conditions contributing to death but not result	ing in the un	derlying cause given in Part I.	23e. Did tobac	cco use contribute to the	e cause of death?		
rds	w require been sig should b	edt	dementia			1 ☐ Yes	2 □ No 3 □ Proba	ably 4 Donknown		
ecc	law re as be 2 sho	Completed				24a. Was an autopsy	24b. Were autop	sy findings available apletion of cause of		
= E	: The	Con				performed	d? death? 1 ☐ Yes			
Vital Records,	Attanding Physician: The law in death. ector: After this certificate has by the funeral director, page 2 s	Be	25. Was case referred to predical examiner?		Othor	eath (Check only one)	A	ssisted		
	Physic ruthis rall dia	2	To tes 2000 Topatient 2016	NOutpatient 8b. Time of	1 3 DOA 4 Nursing	Home 5 Residenc		ring tacilit		
on	oding I th. : After s funer	ation	1 □ Matural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No		,,			
Division of	or Attand after death Director: / in by the f	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At hom building, etc. (Specify)	e, farm, stre	eet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural	Route Number,		
	ital or A rs after ral Directed In Directed	Cer								
	To the Hospital or Attanding Physician: The within 24 hours after dadh. To the Funeral Director: Atter this certificate h. completely filled in by the funeral director, page	edical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and manner stated	edge, death n and/or inv	occurred at the time, date and place estigation, in my opinion, death occ	e, and due to the caus curred at the time, date	e(s) and manner as sta and place, and due to	ated. the cause(s)		
	To the within 2 To the comple	Med	and manner stated. 29b. Signature and title of certifier		29c. License number		Date signed (Month, D	Day, Year)		
	F 3 F 8			MI	D5072	5		2000		
ì	1		30. Wame and address of person who completed cause of death, (Item 2	(Type, F	Print)	1 1	11	21170		
_			Jenniter Kiedinger 8601 Ve	eter	ans Highway N	11/ersvi	lle Mi)	21108		
	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 8 2006	1000						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month November 3, 2006 **Physician** Betty J. 3:45A.™ /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 807 Umbra Street Baltimore n/a | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Feb. 10, 1930 | Maryland 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F 215-24-6211 76 Director Usual Residence of Deceden the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 27 is marked other than "neturel", or Iteme 23e or 28e-f show traumstic event, the Mudical Examiner must be notified at 1X Yes 2 □ No Director Md. n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 807 Umbra Street 21224 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours atter of Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "neturel", or Item any injury or other traumatic event, the Medical Extending once. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 XNo Specify: þ 3 N Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home (unk) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) (unk) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William A. Keene, Jr. (son) 807 Umbra Street Baltimore, Md. 21224

20c. Makked of Disposition

20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Bayview Crematory 11/4/2006Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Faciliaczorowski Funeral Home, P.A. 21. Signature of Funeral Service Licensee 1201 Dundalk Ave Baltimore, Maryland21222 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical as a consequence of) 1715 FA F Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine SBBAZO ed by the attending physicien and detached for use as the burial-transit law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown tor: After this certificate has been signed by it the funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1040170515 198 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 XNo the Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ EB/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10 CVESAGO BVE, RAJO, MD 21237 HOLOG State NOV 0 8 2006

DHMH 17 Rev 1/2001

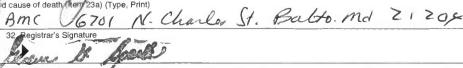
Registrar

State Registrar

NOV 0 8 2006

31. Date filed (Month, Day,

30. Name and address of person who control d cause of death (tery 23a) (Type, Print)



State of Maryland / Department of Health and Mental Hygien 2006 35252 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** NOVEMBER 5, Rose Jeanne Love 2006 1:00 PM /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛛 F Director 208-26-8948 24,1931 Feb. Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County il Hygiene. I other then "naturel", or Items 23s or 28s-1 srium ivent. The Medical Examinar must be notified at 10d. Inside City Limits Director 1 √Yes 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene in Instrument of Health and Mental Hygiene in Instrument, or Items 23e amy njury or other traumatic event, the Medical Examinations 200. 173 Stanmore Road 21212 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: Specify: White 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 4 Supervisor Social Security 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James J. Lacy, Sr. Rose Daily 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Frank M. Love, Jr. (Son) 173 Stanmore, Baltimore, Maryland, 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery Nov. 7,2006 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Peaceful Alternatives Funeral & Cremation Ctr. P.A. of COM 2325 York Road, Timonium, Maryland, <u> 21093</u> 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ACUTE RENAL FAILURE DAYS /Medical Due to (or as a consequence of): Examiner LARGE RIGHT PLEURAL EFFUSION DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physicien: The law requires that the death certificate be executed burial-transit END STAGE CHRONIC OBSTRUCTIVE PULMONARY DI\$ YEARS physician and Due to (or as a consequence of): O. Box 68760. Completed by Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by d be detact Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signated 1 ☑ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed' certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1

Inpatient 2 □ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ۵ 1 ☐ Yes 2/CXNo 3□ DOA t) is After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Waturai 5 Pending Injury death. 1 ☐ Yes 2 ☐ No Director: / 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral Di completely filled in 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 2006 D25886 30. Name and address of person who completed ause of death (Item 23a) (Type, Print) LILIA CEBALLOS, M. D. 7601 OSLER DRIVE TOWSON MARYLAND 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			1 - For State Registrar	State of Ma			t of He	alth and	Mental Hy		06	35253
	Physici /Medic	_	Decedent's Name (First, Middle, Last) ELSIE H. LUC	LOW					2. Date of De Month Novemb	er 5,2	20 ^Y 006	3. Time of Death 5:40 A M
	Examir	er	4a. Facility Name (If not institution, give : Genesis Multi-	Medical			Tows				ty of Death altin	
*	Funeral Director		5. Social Security Number 099-22-9373 6. Security Number 1 C		(In yrs. last birth	Months Yrs.		f Under 24 Hr Hours Mir		23,1925	9. Birth Cou New	place (State or Foreign into) York
	Maryland -f show	tor	10a. State 10b. County		10c. City, Town	or Location	Balt	cimore				10d. Inside City Limits 1 1 Yes 2 □ No
	h with the 3a or 28e	al Direc	10e. Street and Number 2604 Harwood Road			10f. Zip		1224		10g. Citizen of	What Cou	intry?
036	d within 72 hours after death with the Maryland Jane. r than "natural", or lleme 23a or 28e-f show the Medical Exement must be trofflied at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑N If Yes, Give Year or Dates:		13. Was Deced If Yes, spec		anic Origin? (Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)	- 14. Ra Bla Speci	ack, White	ican Indian, , etc. White
Maryland 21215-0036		Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0·12)	cation e completed) College (1-4or 5+	+)	Decedent's Usua (Give kind of wo life. DO NOT us Teacher	al Occupation rk done during se retired)	on ing most of wa	orking	16b. Kind of E	Business/Ir	•
ryland	should be filed ind Mental Hygia in marked other umatic event, it	To Be (17. Father's Name (First, Middle, Last) Albert Hruschka					Elsi	me (First, Middle, e Mordic	k		
	s 1 and 2 should if Haalth and Mer Item 27 is marks other treumatic		Jan Ludlow-daughte		653.	3 Gilda	r Stre	Number or F eet-Ale	exandria,	Virgini	la 22	310
Baltimore,	Page not: M ny or		20a. Method of Disposition 1 Burial 2 Cremation 3		EVANS FO		PELªAN S-BEL A	IR.	-06-06	Fores	t,Hi	11,MD
Bal	permit. Departm Imports any inju		21. Signature of Funeral Service License Condiae & M	E-fado	_	8800 Har	rford R	bad-Park	NS FUNERAL EVILLE,MD 2	1234	ND CRE	MATION SERVICES
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. Tail, leading to inmodel to cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	9.	6 E			ic or respiratory ar	rest,	C	Approximate Interval Between Onset and Death
P.O. Box 68760,	res that the death certificate be executed igned by the attending physician and be detached for use as tha burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome o 1 □Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal death	3 □Ectopic pr 5 □ Other (sp			· · · · · · · · · · · · · · · · · · ·		ate of delive	ery Day Year
	law requires that the as been signed by th 2 should be detache	þ	Part II, Other significant conditions con	tributing to death but	t not resulting in t	the underlying c	ause given ii	n Part I.		bacco use con es 2□No	tribute to t	he cause of death?
al Reco	The ate h page	Completed							24a. Whas a autop perfor 1 \(\text{ Yes} \)	sy	Were autoprior to codeath?	ppsy findings available mpletion of cause of
Division of Vital Records,	or the Hospitel or Attending Physician: within 24 hours after death as the death to the Funerel Director: After this certific completely filled in by the funeral director,	atlon: To Be	27. Manner of Death Natural 5 Pending	ospital: 1 Inpatien 28a. Date of Injury (Month, Day	t 2 ☐ ER/Outp 28b. Tir Year) Inji		Other: 8c. Injury at Work?	4 Nursing I	ath Check only or Home 5 Resid	ence 6 □Ott		59)
Divis	itel or Attures after de el Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	y - At home, farn (Specify)	n, street, factory	, office		28t. Location (S City or Tow	treet and Numi n, State)	ber or Rura	al Route Number,
	To the Hospitel within 24 hours a To the Funerel I completely filled	ledical	29a. Certifier (Check only one) 1 Certifying Phys	ier: On the basis of e	examination and/	Or investigation	in my opinio	on death occ	urred at the time of	late and place	and due to	the eques(a)
	To the To the comple	Σ	29b. Signature and title of certifier	`		290	. License nu	imber	2	9d. Date signe	id (Month,	Day, Year)
6	1		30. Name and address of person who could be should be sh	npleted cause of dea	ath (Item 23a) (T	ype, Print)	onti		cod	suit	Zelik	Day, Year) 2006 0 M0 6164645
	Sta Registr	re.	31. Date filed (Month, Day, Year)	32. Re g stvar	's Signature	Speck	و	3		1 0	-IU M	21

			State of Ma	aryland					lental Hy	giene,		35254
			Registrar		Cei	rtificate	e of Dea	ith	O Data of D	Reg. No.	2006	
Phy	/sicia	n	Decedent's Name (First, Middle, Last) Kenneth Edward Leilich						2. Date of De Month	Day		3 3 M
	ledica amine		4a. Facility Name (If not institution, give street and number)			4b. City.	Town, or Locat	ion of Death	Novem		County of De	
	aiiiiiie		St. Agnec Hosp	ita	1	B	alti.	more			n/a	
Fund	eral		5. Social Security Number 6. Sex 7. Ag	e (In yrs. I	ast birthday)	If Under Months	1 Year If Ur Days Hou	nder 24 Hrs.	8. Date of Bir (Month, Di Oct. 8	rth av. Year)		rthplace (State or Foreign
Direc	ctor		216-01-2700 ¹ ⊠ ^{M 2□ F}	94	Yrs.		24,0		Oct. 8	, 19	12 Ma	aryland
and	=		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	ocation						10d. Inside City Limits
Mary		ğ	Maryland Baltimore	Ca	tonsvi	lle						1 ☐ Yes 2 🙀 No
h the	Tool .	Director	10e. Street and Number			10f. Zip	Code			10g. Citiz	zen of What C	ountry?
036 ours after death with the Marylan al', or tems 23a or 28e-1 show	a la	ie l	601 Maiden Choice Lane			2	1228			US	SA	
ar dez	<u> </u>	Funerai	11. Marital Status 12. Was Decedent Amed Forces?			Was Deced If Yes, spec	ent of Hispanio	Origin? (Spe kican, Puerto	ecify Yes or No Rican, etc.)	o- 1	14. Race - Am Black, Wh	erican Indian, ite, etc.
36 rs affe	TIMES I	by F	1 X Never Married 2 ☐ Married 1 X Yes, Give 1 Yes, Give Year or Dates:	40		1 □ Yes 2	No Spe	cify:			Specify:	White
1215-0036 within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28e-1 show		ed	15. Decedent's Education		16a. Deced	dent's Usua	f Occupation			16b. Kir	nd of Busines:	s/Industry
21.25 Fig. 7.	Media.	pie	(Specify only highest grade completed) Elementary/Secondary (0-12) Colfege (1-4or 5	i+)	(Give life. I	kind of wor DO NOT us	k done during e retired)	most of worki	ng			
d 21 filed wit Hygien	event, <u>the Medical</u>	Completed	11 0		Servi	.ce Re	present	tative			Tire	
be file	Ne ve	Be	17. Father's Name (First, Middle, Last)				18. M	lother's Name	(First, Middle	, Maiden	Sumame)	
aryla should nd Mer	natic	၉	Louis Leilich		405 14-77			eresa W				71.0
Maryland 21215-0036 nd 2 should be filed within 72 hours all lith end Mental Hygiene.	traur		19a. Informant's Name/Relationship (Type, Print) Louis E. Leilich / Brother		1				I Route Numb			.le, Md.
Baltimore, Maryland 212: permit. Pages 1 end 2 should be filed within Department of Heelth end Mental Hygiene. Important: if Item 27 is marked other than	other		20a. Method of Disposition	20b. Pf	lace of Dispo	sition /Nam	e of		ate #3210		cation - City o	
MOT Pages nent of l	70 0		1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Peqation 5 ☐ Other (Specify)	i	emetery, cren 7 Cathe			11/9	/2006	Balt	imore	Maryland
Battimore, permit. Pages 1 er Department of Hee Important: if Item		Ī	21. Signatur of Fineral Servo-Licensee									e, Inc.
a gg	E B		Tibend Ome	\sim								land 21229
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lir	the death								Approximate Interval Between
, Physic			Immediate Cause (Final disease or condition	ha.	1 1	1.57	100	Ac	cicle	2		Onset and Death
/Medi Exami			resulting in death) Due to (or as	a consequ		0-5						13273
			Sequentially list conditions, if any, leading to immediate	a consedi	ence of							
B/4 7	insit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events		3							
execul	burial-transit	Exa	resulting in death) Last C. Due to (or as	a consequ	ence of):							
	ine bu	dical	d									
	a as a	Med	IF FEMALE:			550						
	or use	by Physician/Me	23b. Was decedent pregnant in the past 12 months?	2 Fetal	death 3	Ectopic pre				2	3d. Date of de	Day Year
D.O. I	Deu:)sic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at 9 ☐ Unknown	time of de	eath 5∟	Other (spe	ecify)					Duy Tour
ernnet) ords, P.O. requires that the d	deta	F.	Part II. Other significant conditions contributing to death be	ut not resu	ılting in the u	nderlying ca	use given in P	art I.	23e. Did 1	lobacco us	se contribute l	o the cause of death?
Records, Phe law requires tha	B 1	٥ و	Cornery Actor		5065		-			Yes 2		robably 4 Unknown
CO S Ped S	pinous	ete	Dichalas						24a. Was	an	24b. Were a	utopsy findings available
~ 0 c	page	Completed	- J CONGAE						auto	psy ormed?	prior to death?	completion of cause of
Vital Ficien: Th	ō	Be C	25. Was case referred to medical				26. P	lace of Death	1 ☐ Yes	100000000000000000000000000000000000000	1 10 10	s 2□No
s s		2	examiner? 1 ☐ Yes 2 ☑ No Hospital:		ER/Outpatien			Nursing Hor	ne 5□Resi	dence 6	☐Other (Spe	ecify)
_ E & ê	<u>ē</u> :	<u>ë</u>	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injur (Month, Day)	ry y Year)	28b. Time of Injury		Bc. fnjury at Work?		28d. Describe	how infury	occurred	
/ision /ision Attending r death.	90	Cat	2 Accident investigation 3 Suicide 6 Could not be 389 Bloom of Initial	At he	to	M	1 Yes 2		206 Leastine (· C44	4.44	
Divi	<u> </u>	Certification:	4 Homicide determined 28e. Place of Initial 28e. Place of Initial 28e. Place of Initial 28e.	s. (Specify	nie, iann, str	eet, ractory,	опісе	-	City or To	wn, State)	Number or F	lural Route Number,
Divisio To the Hospital or Attendi within 24 hours eiter death. To the Funeral Director: A			29a. Certifier 1 Certifying Physician: To the best of	of my know	wledge, death	h occurred a	it the time, date	e and place, a	and due to the	cause(s)	and manner a	s stated.
the Ho hin 24 t	oletely	Medical	(Check only and manner state) (Check only one) 2 Medical Examiner: On the basis of and manner state (Check only one)	examinati	ion and/or inv	vestigation,	in my opinion,	death occurre	ed at the time,	date and	place, and du	e to the cause(s)
To the To	E :	Σ	29b. Signature and title of certifier			29c.	License numb	per		29d. Date	signed (Mon	th, Day, Year)
	1					Y)62-	157		No	remb	-01,2006
10)	11		30. Name and address of person who completed cause of de			·			illo	1 1		mb 21230
1	Charle		31. Date filed (Month, Day, Year) 32. Registra		455 ure ▲		kens	HVC		DaHi	more,	ynb 21230
, Re	State gistra		31. Date filed (Month, Day, Year) 32. Registra	K	4204	3						

Bonnie Loeb

06-08148 Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 0950 hrs Bonnie Sue Loeb **Medical Examiner** October 29, 2006 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore City** 2715 Hollins Ferry Road 7. Age (In yrs. last birthday) 9. Birthplace (State or 5. Social Security Number If Under 1 Year If Under 24Hrs. Date of Birth(MM/DD/YYYY) **Funeral** Foreian Months Days Hours 217-76-0887 48 Director Country) M 2 X F 10. 1958 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Baltimore N/A 1 X Yes 2 No MD 23a or 28a-f show notified at once. 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 2715 Hollins Ferry Rd. 21230 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11 Marital Status 12 Was Decedent Ever in U.S. Armed Forces? must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married Specify. White 1 Yes 2 X No specify: hours after 3 X Widowed 4 Divorced If Yes, Give Year item 27 is marked other than "natural", traumatic event, the Medical Examiner ģ 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) rmit. Pages I and 2 should be filed within 72 I ppartment of Health and Mental Hygiene. portant: If item 27 is marked other than "i jury or other traumatic event, the Medical E Baltimore, MD 21215-0036 Payroll Coordinator Service Agency 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Geraldine Middleton John Loeb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3379 Dulany Street Balitmore Md 21229 Terri L. Clauss/Sister 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State West Arundel Crematory 11-4-2006 Odenton, Maryland Other Specify: Donation 5 ignature of Fur ral Service License 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd. Lansdowne MD 21227 at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and 23a. Part I. Enter the disease or complications Physician failure. List only one cause on each line Medical Death a. Complications of morbid obesity Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): certificate be executed and Physician/Medical UNPENDED AMENDED Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Fetal death Month past 12 months? Pregnant at time of Other (Specify) The law requires that the death 1 Yes 2 No 9 V Unknown death Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. ģ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available has been 24a Was an prior to completion of cause of autopsy performed? Yes 2 ✔ N Yes 2 No certificate 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Other; DOA Nursing Home 5 Residence 6 ✓ Other: Scene Inpatient 2 ER/Outpatient 3 After this 1 V Yes ۲ No 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 V Natural Yes 2 No Director: 5 Pending 24 hours after death. 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined To the Funeral Δ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie O.C.M.E. October 30, 2006 30. Name and address of person who completed cause of death (Item 23a) 10 Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) egistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Tv

AMEND THE #206, Perfett, 6861, 1179706, WS Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene	3	5%	25	5 (
Cartificate of Donth				

1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year 2:15 PM 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ball more Simanian 2000 If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month. Day, Y 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 260-16-488 1. M 2□ F Yrs. Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Iteme 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No by Funeral Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iteme 23a eny injury or other traumatic event, the Medical Examples page. 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify:1 3 Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mojher's Name (First, Middle, Maiden Sumame) ပ 19a. Informant's Name/Rela onship (Type, Print) a wighter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28 Merco 20b. Place of Disposition (Name of cemetery, crematory or other place) 11.212 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🂢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/8/2006 Green Mount Mount Crematory 22. Name and Address of Furlity Joseph L. Rus 21. Signature of Funeral Service Licensee Joseph L. Russ Funeral Home, P.A. 2222 W. North Ave. Buto. Md. 21216 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart gillure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPS:5 **Physician** /Medical Due to (or as a consequence of): Examiner Presono. a. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 physician Completed by Physician/Medical ESRI HO IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 **W**Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ♣Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 1 ☐ Yes this To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 @ Natural 5 Pending investigation deeth. 1 Yes 2 No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funaral Dire 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Res 600 11/4/6 MO Blik 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) selanh Alav. (Good samanta K Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/200

かくてつ

7

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. 80.006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month **Physician** GORDON 5,2006 WILLIAM LIDDICK NOV. 2:10 pm /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner EASTPOINT NURSING HOME BALTIMORE BALTIMORE If Linder 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1**X** M 2□ F 098-22-9458 76 Director JUNE 8,1930 PENNSYLVANIA Usuel Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits show r than "natural, or items 23s or 28s-f short the Medical Examiner must be notified at 1 Yes 2 No Director MD. N/A BALTIMORE 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 603 S. ANN STREET 21231 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after daath v Department of Health end Mental Hygiena. Important: If Item 27 is marked other than "natural", or Itema 23 any injury or other traumatic event, the Medical Examinat must Funeral Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Affined Polices 1 1 XYes 2 No If Yes, Give Year or Detes: 1948 – 50 1 Never Merried 2 Married 1 ☐ Yes 2X No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 LABORER MANUFACTURING 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **GEORGE** Α. LIDDICK BURNICE HANEY 19a. Informant's Name/Relationship (Type, Print)
. BROTHER-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) WILLIAM MITCHELL/IN-LAW 7813 NEW BATTLE GROVE, BALTIMORE, MD. 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 X Buriat 2 ☐ Cremetion 3 ☐ Removel from State 4 □ Donation 5 □ Other (Specify) ST. STANISLAUS CEMETERY 11/8/06 BALTIMORE, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility
LILLY & ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD. 21231 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner attending physicien end for use es the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest BRONARY ARTERY DISEASE

Due to (or es e consequence of): Physician/Medical ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ å 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed 24a. Wes an autopsy performed? certificata has 1 Tyes 2 ENo 1 ☐ Yes 25 No 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 2 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this eral Director: After thi filled in by the funeral 27. Manner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of Injury 28c. injury at Work? 28d. Describe how injury occurred Certification: 1 Destural
2 Accident 5 Pending investigation death. 1 Yes 2 No 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or Att within 24 hours aftar d 4 ☐ Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.
2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a, Certifier (Check only one)

DHMH 16 Rev 6/95

with the Merylenc

Saltimore, Maryland 21215-0036

the daath certificate be executed

Division of Vital Records, P.O. Box 68760.

State Registrar

NOV o R 2006

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)

29b. Signature and title of certifier



29c. License number

29d. Date signed (Month, Day, Year)

Place Dundalic MD 21222

State of Maryland / Department of Health and Mental Hygien 0 6

1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Month 3:00 Martha Churchill Markush November 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ellicott City

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 12625 Triadelphia Rd. Howard 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗷 F 75 578-62-6360 Director New Hompshire November 2, 1930 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r then "natural", or items 23a or 28a-f ehow the Medical Exempler must be notified at 1 ☐ Yes 2 No Director Howard Ellicott City Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21042 USA 12625 Triadelphia 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filled within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 Is marked other then "natural", or Ite 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Musician University 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kenneth Churchill Miriam 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dr. Robert Evan Markush / Husband 12625 Triadelphia Rd Elliestt City, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location · City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department o Important: If eny injury or once. Anatomy Giffs Registry Hagover, MD 4. Donation 5 ☐ Other (Specify) November 1, 2006 22. Name and Address of Facility Arestony Gifts Registry 21. Signature of Funeral Pervice Licens e 7522 Connelley Drive suite P. Hanover MP 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** ALZheimer's Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any, loading to in addate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of) ned by the attending physician and or detached for use as the burial-transit The law requires that the death cartificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Seizure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ nknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Depression 24a. Was an autopsy performed? Hospital or Attending Physician: 24 hours after death. Funsral Diractor: Atter this certifica 25. Was case referred to medical 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 25 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 XNatural 2 Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funaral C completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) wicks D40369 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6350 Stevens Forest Rd Columbia MD 21046 Kanthi Wicks 31. Date filed (Month, Day, Year) 32. Repistrar's Signature State NOV 0 8 2006

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 5 **Physician** MASON 1:00AM LIRAbeTh 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Richie Hospice Balto. Soseph

5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 229-28-7839 1 ☐ M 2 F Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehov permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Iteme 23e or 28e1 ehov any injury or other traumatic event, the Mardical Examinations to entitled at 1 ☐Yes 2 ☐ No Balt, more MD Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Lanvale Street USA 300 21213 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HIME MAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Tester Mason LOU UNNIA Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Audgins 1814 Ruthland Ave. Ballo. Md. 21213 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 DCremation 3 Removal from State 4 Donation 5 Other (Specify) Bay view Crematory 10 22. Name and Address of Facility Mallettis Melitablettan Chapet 21. Signature of Funeral Service Lieuns Broadway Baltimor Md. 51213 23a. Part1. Enter the disease or com shock, or heart failure. List only Immediate Cause (Final disease or condition implications that caused the death: by one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Pnysician resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 € No 23d. Date of delivery 3 □Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Ceat 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examines: On me basis or examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

		•	1 - State Registrar	State of Maryla		artment of I			iene •g. No. 20 (35260
	Physici /Medio		1. Decedent's Name (First, Middle, Last)	I M	CCLE	LLAI	$\sqrt{}$	2. Date of Dea Month	Day Y	ear 23 CVM
	Examin Funeral Director	er	4a. Facility Name (If not institution, give s 12332 Shadetree Lane 5. Social Security Number 5.77-20-4873 6. Sex		rs. last birthday, Yrs.	4b. City, Town, of Laure laure	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day May 10 1	Year)	eorges Birthplace (State or Foreign Country)
	Director Maryland Illed II	tor	Usual Residence of Decedent 10a. State	10c.	City, Town or L	ocation		May 10 I	921	Maryland 10d. Inside City Limits 1 Yes 2 No
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. importent: if Item 27 is marked other then "naturel", or items 23a or 28a-f ehow eny injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	10e. Street and Number 12332 Shadetree Lane 11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1	n U.S. 13.	10f. Zip Code 20708 Was Decedent of If Yes, specify Cub 1 Yes 288 No	Hispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No-	14. Race -	tes America American Indian, White, etc.
Maryland 21215-0036	led within 72 hou ygiene her then "nature it, the Medical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12	cation	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of word)	rking	16b. Kind of Busin	ness/Industry
aryland	should be fil and Mental H is marked ott	To Be	17. Father's Name (First, Middle, Last) Ernest B. Prangley 19a. Informant's Name/Relationship (Ty)	рө, Print)	19b. Maili	ng Address (Street		ne (First, Middle, i A. Stoute ural Route Number	nburg	ate, Zip Code)
Baltimore, M	Pages 1 and 3 lent of Health nt: if item 27 iry or other tri	ı	William A. McClellan/Hu 20a. Method of Disposition 1 Daurial 2 Cremation 3 B 4 Donation 5 Other (Specify)	emoval from State	b. Place of Dispe	osition (Name of matory or other pla		-	20c. Location - Ci	ty or Town, State
Balti	permit. Departm importe eny inju		21. Signature of Funeral Service Gense Shawn E. Wells 23a. Part1. Enter the disease, or compli	Man EV	Velle 7	601 Sandy	ess of Facility Fle	Laurel	Home Maryland	20707 Approximate
8760,	hysicien be executed / Medical Examine and physicien and physicien and the purial-transit is the purial-transit	dical Examiner	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, tary, backing to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con:	Melwassequence of):	ve	ig, soon as cardiac	or espiratory and	531,	Interval Between Onset and Death S DOT
9	Attending Physicien: The law requires that the death certificate be executed in death. If death. ector: After this certificate has been signed by the attending physicien and by the tuneral director, page 2 should be detached for use as the burral-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of	etal death 3[□Ectopic pregnanc	у		23d. Date of Month	
ords, P.	w requires that been signed b should be deta	ρ	Part II. Other significant conditions con	tributing to death but not	resulting in the u	nderlying cause gr	en in Part I.	1 □ Y€	es 2 □ No 3	ute to the cause of death?
itai Rec	ian: The law nificete has b itor, page 2 s	Be Completed	25. Was case referred to medical				26. Place of Dea	24a. Was a autops perform 1 Yes 2	priod? dea	re autopsy findings available or to completion of cause of th? Yes 2 No
Division of Vital Records, P.O. Box	To the Hospitel or Attending Physician: The ta within 24 hours after death. To the Funeral Director: After this certificete has completely filled in by the funeral director, page 2	Certification; To E	27. Manner of Death 1 Statural 5 Pending 3 Accident investigation	ospital: 1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year	2 ER/Outpatier 28b. Time of Injury	f 28c. Inju	ner: 4 🗆 Nursing H	ome 5 Reside		(Specify)
DÍX	i gite		3 Suicide 4 Homicide 29a. Certifier Secrifying Physics	28e. Place of Injury - A building, etc. (Special Control of the best of my			me, date and place	City or Towr	i, State)	or Rural Route Number,
	To the Hospitet or within 24 hours after To the Funeral Dirac completely filled in I	Medical	29b. Signature and title of certifier	and manner stated.	aination and/or in	29c. Licens	opinion, death occu	rred at the time, di	ate and place, and 9d. Date signed (#	of due to the cause(s) Month, Day, Year)
	10		Ohief Medical 30. Name and address of person who co Michael J. LaP	enta, MD, 4	45 Defe	Print) nse Highw		polis, MI		2006
· ·	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 8 21	32. Registrar's Si	- 6	books				

			for State Registrar	State of Mary		artment of Hea rtificate of De			ene 2006	35261
	Dhysiai	an.	1. Decedent's Name (First, Middle, Las	t)				2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Maggie Manni						r 4, 2006	11:50A M
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, or Lo	cation of Death Cern		4c. County of Dear	
		4	8034 Fair Breeze 5. Social Security Number 6. Se		yrs. last birthday)		Under 24 Hrs.	8. Date of Birth		
	Funeral Director			DM of Sec	76 Yrs.		Hours Min.	May 1,1	930 Mic	thplace (State or Foreign punity) Phigan
	p ,		Usual Residence of Decedent 10a, State 10b, County	10	c. City, Town or Lo					104 1-14 05 11-15
	ehov	'n	,		Severn	cation				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	28e-f	ect	MD Anne An	under	Severn	10f. Zip Code		10	g. Citizen of What Co	
	3a or	0	8034 Fair Breeze D	rive		21144			United S	-
386	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28e-f ehow says injury or other traumatic event, the Medical Examinar must be notified at ODGs.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates:		Mas Decedent of Hispa f Yes, specify Cuban, N 1 ☐ Yes 2 🛣 No S	anic Origin? (Spe Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: V	erican Indian, e, etc. White
ည်	72 hor	Completed	15. Decedent's Ed (Specify only highest gra	ucation	16a. Dece	dent's Usual Occupatio	nn ina most of work	1	6b. Kind of Business	Industry
2	han "	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done during DO NOT use retired)		, ig	Computir	na
2	Hygier Hygier Ther ti	S	12 17. Father's Name (First, Middle, Last)			Data Entr		e (First, Middle, M		
and	ould be f Mental I Marked of	To Be		Slayden		10		Booker	alderr Samame)	
Maryland 21215-0036	shoul ind Mari i mari	۲	19a. Informant's Name/Relationship (7		19b. Mailir	ng Address (Street and	Number or Rura	al Route Number,	City or Town, State, 2	Zip Code)
	end 2 eith a n 27 is		Linda Bothne, Dau			Fair Breez	e Drive	, Severn	, MD 21144	
altimore,	of He of He if item	1	20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 🖸			sition (Name of natory or other place)			Oc. Location - City or	
₹	tment tent: tent:		4 □Donation 5 □ Other (Specify)		uneral Chap				
Ba	Depar Impor eny in		21. Signature of Fundinal Service Licen	see M0111		. Name and Address of 7221 Graybu				
			23a. Part1. Enter the disease, or composhock, or heart failure. List only	plications that caused the one cause on each line.	death. Do not ent	er the mode of dying, s	such as cardiac o	or respiratory arres	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a retos	total C	oncecd	Uc	eter		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a co	nsequence of):	8				1
		er	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a co	nsequence of).					
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
Ö,	e exectien en	Ex	resulting in death) Last	Due to (or as a co	nsequence of);					
68760,	licate be executed physicien end s the burial-transit	edical		d						
P.O. Box 6	The law requires that the death certifi He hes been signed by the attending I age 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pi 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
	s that	ьу Рh	Part II. Other significant conditions co	ontributing to death but no	ot resulting in the u	nderlying cause given i	n Part I.	23e. Did toba	scco use contribute to	the cause of death?
g	equire sen si							1 Yes	2 □ No 3 □ Pr	obably 4 Unknown
Vital Records,	8 CA	Completed						24a. Was an autopsy performe 1 Yes 2	prior to	stopsy findings available completion of cause of
⋚	sician: Th certificete rector, pag	o Be	25. Was case referred to medical examiner?	Hospital:		0		(Check only one,		
ō	Attending Physician: or death. ector: After this certifice by the funeral director.	\vdash	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Injury	2 ER/Outpatier 28b. Time of	IL SLI DOA		me 5X Residen 28d. Describe how	ce 6 Other (Sperinjury occurred	cify)
<u></u>	ath. r: After e funer	atlo	1 Natural 5 Pending 2 Accident investigation	(Month, Day Ye	ar) Injury		2 🗆 No			
Division of	after death after death Director:	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, str pecify)	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ıral Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funaral Director: After this certificete hy completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one) 2 Medical Exam	ysician: To the best of my iner: On the basis of exa and manner stated.	y knowledge, death mination and/or in-	n occurred at the time, overstigation, in my opinion	date and place, on, death occurr	and due to the cau ed at the time, dat	ise(s) and manner as e and place, and due	stated. to the cause(s)
	ro the	Med	29b. Signature and tille of certifier	and married stated.	11-	29c. Licenseynu	umber	290	d. Date signed (Mont	h, Day, Year)
	(1// long	Ah	2/	> X/3	1557	/	Vovembo	-62001
	10		30 Name and address of person who o	completed cause o death		Print)	1 / /	7	0/0	-62006 nie Nd. 406/
			B1. Date filed (Month, Day, Year)	22. Resitrar's	N 30 Signature	J HOSP	1) tull	ITWO, C	Menbur	n'e/W. 2/06/
	Sta Registr		NOV 0 8	2006	U &	Soll		Ŭ		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month 0 7^{ay} Juan Maldonado 2006 01:50pm /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 26 South St. Annapolis Ann Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 09-14-1946 5. Social Security Number Sex X⊡XM 2□F 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Hours Days 582-98-4749 Puerto Rico 60 Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene. s marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ıral", or items 23a or 28a-f shov Examiner must be notified at 1X Xes 2 □ No MD Arundel Ann Annapolis Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26 South St. 21401 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2**X** Xo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify:Puerto Rican Baltimore, Maryland 21215-0036 White X ves 2 No Completed by 3 ☐ Widowed 4X Divorced "natural" permit. Pages 1 and 2 should be filed within 72 hr Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any Injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Lawyer Goverment 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cataline Rivera Juan Malonado ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13732 Lakeside Dr. Clarksville MD 21029 19a. Informant's Name/Relationship (Type. Print) M. David Vaughn/friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 11-09-06 1 ☐ Burial 2 🛣 remation 3 ☐ Removal from State Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CAFA \$717 Green Pastures Dr Baltimore MD 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Pancreutic 12 moiths Lancer disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner as been signed by the attending physician and 2 should be detached for use as the burial-transit or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page performe certificate 1∐ Yes 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes **3**€ No 2 ER/Outpatient 3 DOA 1 ☐ Inpatient Medical Certification: To After this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 ☐ Pending investigation Natura! 1 Yes 2 🗆 No ours after death.

neral Director: A
filled in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier November 08, 2006 D62878 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wagner-Johnston 401 N. Broadway Baltimore, MD 2123 31. Date filed (Month, Day, Year) Registrar's Signature State NOV 0 8 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Nov. 5, 2006 Jennie Munsterteiger Marie 1442 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 579-28-3780 1 □ M 2 😡 F 80 Feb. 9, 1926 Director Yrs Wash., D.C. Usuel Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or items 23s or 28s-f show other traumatic event, the Madical Exeminer must be notified at MD Prince George's Director Laurel 1 ☐ Yes 2 ☑ No 10e. Street and Number 7407 Berry Leaf Drive 10f. Zin Code 10g. Citizen of What Country? WITH 20707 USA death v by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel', or item eny injury or other traumatic event, the Madical Exercited ODE. 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 Yes X No Specify: Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Executive Secretary N.I.H. 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles A.Mangum Jennie Abell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) Susan M. Schiavone/Daughter 428 Yorkshire Drive Severna Park, Md. 21146 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X8urial 2 □ Cremation 3 □ Removal from State Cedar Hill Cem. 11/09/06 4 ☐ Donation 5 ☐ Other (Spec) Suitland, Maryland Funeral Service Licensee 21. Signature PHILIP ACTOS RINALDI FUNERAL SERVICE, P.A. Beling 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to for as a conseque Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a conse Examiner the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à page 2 should be Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has this certificate 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

Yo the Funeral Director; After this certifice After this certification funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Feath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Chalural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

All Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and addr-ss of person who completed cause of death (Item 23a) (Type, Print) 7600 Carroll Avenue Takoma Park, Md Nasreen M. Kango MD 32. Registral's Signature 31. Date filed (Month, Day, Year) State NOV 0 8 2006 > Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month Year armara a November 2006 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, 4c. County of Death **Examiner** Mary land Baltimore Medical Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number 9. Birthplace (State or Foreign **Funeral** 1 M 2 F 61 218-90-0703 Greece **Director** Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at MD Montgomery Rockville 1 ☐Yes 2X No Director 10f. Zip Code 20853 10e Street and Number 10g. Citizen of What Country? 4724 Miltfred Terrace USA permit. Pages 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumant. Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 M Married White 1 ☐ Yes 2 🗓 No Specify 2 Specify 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Glinou Nickolas Astras 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4724 Miltfred Terrace Rockville, Md 20853 Vassilios Marmaras/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐Removal from State Gate of Heaven 11/09/06 Silver Spring, Md. 4 □Donation 5 Other (Specify) 21. Signatur Funeral Service Lice PHILIP Addess RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 50 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 XNo Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 0625 Completed 1 ☐ Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? Lonic 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only orle Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ၉ 1 npatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours TScrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2

State Registrar

31. Date filed (Month, Day, Year) 32. F

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Redistrar's Signature

Baltimore MD

			1- State of Maryland / Departm	nent of Health an	R	log. No. UUb	35265
	Physicia	an	1. Decedent's Name (First, Middle, Last) Robert Lee McKinney		2. Date of Dea Month	Day Year	3. Time of Death 4:25 PM
	/Medic Examin			City, Town, or Location of D	Death	4c. County of Death	
			Franklin Square Hospital Center 5. Social Security Number V 6. Sex 7. Age (In yrs. last birthday) H.	Bosedale Under 1 Year If Under 24	Hrs. 8. Date of Birth	a Birth	place (State or Foreign
	Funeral Director		214-03-0250 1 M 2 F 87 Yrs. Mo		Min. (Month, Day March 2	0,1919 Mar	Lyland
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	n			10d. Inside City Limits
	ith the Marylar or 28a-f ehow	ţo	Maryland Baltimore Ba	ltimore			1 ☐ Yes 2 No
F	death with the Maryland ms 23s or 28s-f show rmust be notified at	Funeral Director	10e. Street and Number 7711 Bluegrass Road	Of. Zip Code 21237		10g. Citizen of What Cou	intry?
be	death v	neral		Decedent of Hispanic Origin s, specify Cuban, Mexican, P	? (Specify Yes or No-		
Acber 5-0036	ours after el', or iter	by	1 □ Never Married 2 X Married 1 X Yes 2 □ No	es 2X No Specify:	ruerto riican, etc.)	Specify: Who	
	n 72 ho "netur	Completed	(Specify only highest grade completed) (Give kind life, DO N	s Usual Occupation of work done during most of IOT use retired)	f working	16b. Kind of Business/li Automatic 1	
16c	d withi giene. er then	Somp	Elementary/Secondary (0-12) College (1-4or 5+) Court			Processing	
C KINNEY Maryland 2121	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla. Depertment of Heath and Mental Hygiene. Important: If Item 27 is marked other then "neturel", or Items 23a or 28a-f ehov eny injury or other treumatic event, its Medical Examinar must be notified at once.	To Be (17. Father's Name (First, Middle, Last) Vernon Lee McKinney		Name (First, Middle, ice Marie		
(Man)	d 2 sho th and I treum		102	idress (Street and Number of Luegrass Road		·	
Ze,	of Heal		20a. Method of Disposition 20b. Place of Disposition cemetary, cremator	(Name of ry or other place)	Date	20c. Location - City or T	Fown, State
$\mathcal{M}_{\text{Baltimore,}}$	t. Pag rtment rtent: h		4 □ Donation 5 □ Other (Specify) Vulaney Val	Rey Mem' L 11			
Bal	Depermine Depermine Impo		The state of the s	05 Belair Rd.			
	Physician		23a Part. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	e mode of dying, such as ca			Approximate Interval Between Onset and Death
	/Medical Examiner		Due to (or as a consequence or):	11 4101 9 213	TIESS X	J/Idiome	
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury)				
	ate be executed hysicien and the buriat-transit	Examiner	Cause (Disease or injury that initiated events c				
3760,	ate be e nysicier he buria	cal					
O. Box 68	Attending Physician: The law requires that the death certificate in death. ector: After this certificate has been signed by the attending phys by the funeral director, page 2 should be detached for use es the	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ector 4 Pregnant at time of death 5 Oth 9 Unknown	opic pregnancy er (specify)		23d. Date of deli	very Day Year
S,	es that gned by be deta	by Ph	Part II. Other significant conditions contributing to death bul not resulting in the under	ying cause given in Part I.		obacco use contribute to	
ord	requir been si should I	eted	Propertionsion Diabetes Mellitu	5 benigri	1 N		obably 4 Unknown topsy findings available
Rec	ding Physician: The law requir h. After this certificete has been si funeral director, page 2 should	dmo	Prostate Hyper Troping		autop perfo		completion of cause of
/ital	clan:] ertifice ector, p	Be	25. Was case referred to medical		of Death (Check only o	-7-	
of V	Physic rthis corral dire	P	1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3	B DOA Other: 4 Nursi 28c. Injury at Work?		dence 6 Other (Spec	ify)
ion	death. ctor: Afte y the fune	atlor	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation	Work? M 1 Yes 2 No	0		
Division of Vital Records, P.O.	of or Atte	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify)	factory, office	28f. Location (5 City or Tov	Street and Number or Ru wn, State)	ral Route Number,
	To the Hospital or Attenwithin 24 hours efter deat within 24 hours efter deat To the Euneral Directors completely filled in by the	Medical C		curred at the time, date and gation, in my opinion, death	place, and due to the occurred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
	To the compl	Me		29c. License number		29d. Date signed (Month	
			30. Name an lad ress of person who completed cause of death (Item 23a) (Type, Prin	16500	000	11/04/2	
d els	10		De Hanin Mkintila an	Franklin	3 quare	Drive Bull	COG.
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) NOV 0 8 2006 32 Registrar's Signature		V		

		•	For State Registrar	State of	Marylan	d / Depa	artment of H	lealth a Death	and Me		iene []	06	35266
	Physici	an	1. Decedent's Name (First, Middle,	Last)		MI	pride		1	2. Date of Death Month	Day	Year	3. Time of Death
	/Medio Examin		Robert 4a. Facility Name (If not institution, The Johns Hopkin		ber)	1100	4b. City, Town, or Baltima	Location of		October	4c. County n/		07:25 M
	Funeral Director				. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day, Dec. 20	Year) 1936	Cour	place (State or Foreign ntry) y Land
	Maryland	tor	10a. State 10b. County Md. Harfo	rd	10c. Cit	y, Town or Lo	ecation Edgewood					1	0d. Inside City Limits 1 ☐ Yes 2 No
	death with the Maryland ms 23a or 28a-f ehow rinual te notified at	ai Director	10e. Street and Number 1905 Bellflower	Court			10f. Zip Code 21	.040		10	Og. Citizen of V		ntry?
9-00-c	permit. Pages 1 and 2 should be liled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Brandinatist lifem 27 is marked other then "natural", or liems 23a or 28a-1 ehow any injury or other traumatic svent, it a Medical Exactinar manter traumatic standing an once.	by Funeral	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Deced Armed Ford 1 Yes 2 If Yes, Give Year or Dat	es? 2. □Mo		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2☐ No	ispanic Orig in, Mexican, Specify:	gin? (Spec , Puerto R	ofy Yes or No- lican, etc.)		k, White,	can Indian, etc. ite
0-61717	d within 72 hd giene. ir then "natur ir e Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 10 years		4or 5+)	(Give	dent's Usual Occupi kind of work done o DO NOT use retired	ation during most	of working	g	(Gene	ral l	dustry Motors)
yland	2 should be file and Mental Hy, is marked othe raumatic svent,	Be	17. Father's Name (First, Middle, L Marvin H. McBrid	е						(First, Middle, N Swick	laiden Suman	16)	
Mar	and 2 sho alth and 1 27 is m or traum		19a. Informant's Name/Relationshi Bill McBride/sor				ng Address <i>(Street a</i> MacPhail						Code)
altimore	Pages 1 and of He Int: If Item Ity or oth		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe				esition (Name of matory or other plac em 1 Gdns		Da		oc. Location - Cumber1	•	
Dall	permit. Departn Imports any Inju		21. Signature of Funeral Service Li	censee			2. Name and Address chimunek 10 W. Mac						
	Physician /Medical Examiner		23 Part 1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a. Acu	ch line.	n. Do not ent	er the mode of dyin	g, such as o	cardiac or	respiratory arre	st,		Approximate Interval Between Onset and Death Year
	cate be executed physician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	r as a conseq								
00/00	ficate be physicia ts the bur	dicai		d.									
.O. DOX	Ine law requires that the death certilics ite has been signed by the attanding ph bage 2 should be detached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2 ☐ Fete ntattime of d	I death 3	Ectopic pregnancy Other (specify)					te of delive	ery Day Year
ords, r	w requires that the de been signed by the s should be detached	þ	Part II. Other significant condition	s contributing to dea	ith but not resi	ulting in the u	nderlying cause give	en in Part I.		23e. Did tob	N	ribute to th 3 ☐ Prob	ne cause of death? ably 4 \Bunknown
יים וו	Prystoten: The law re this certificate has be al director, page 2 sho	Completed								24a. Was an autopsy perform	ed?	prior to con death?	psy findings available impletion of cause of 2 No
=	s certifi	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 10 In	patient 2	ER/Outpatier	nt 3 DOA Othe	or		Check only one e 5 ☐ Resider		/0	
5	ng Pny fter this		27. Manner of Leath	28a. Date of		28b. Time of				3d. Describe ho			//
DISINI	To the Hospital of Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifics completely filled in by the funeral director, I	ertification:	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	tion t be 28e. Place o		ome, farm, str		Yes 2□N		Bf. Location (Str. City or Town,	eet and Numb State)	er or Rura	l Route Number,
	No Mospital	edicai C	29a. Certifier (Check only one) Certifying 2 Medical E	Physician: To the base caminer: On the base and manner	sis of examina	wledge, deat tion and/or in	h occurred at the tim vestigation, in my or	ne, date and pinion, death	d place, an	nd due to the ca d at the time, da	use(s) and ma te and place,	inner as st	ated. the cause(s)
)	Withi Toth	W	29b. Signature and title of certifier		20.		29c. License)		d. Date signed		
0	20		30. Name and address of person w		of death (Item	23a) (Type,	Print)	Sal	lim	me Mr	212	305	2006
	Sta	ite	31. Date filed (Month, Day, Year)	32. Re	gistrar's Signa	ture				711			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** DCT /Medical give street and number 4b. City, Town, or Location of Death Examiner If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month_Day) 7. Age (In yrs. last birthday) Funeral Days Min Yrs. Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. Count 10d. Inside City Limits or iteme 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at N To Be Completed by Funeral Director Yes_2 No 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No 14. Race - Ameri Black, White Marital Status Hispanic Origin? (Specify Yes or No ban, Mexican, Puerto Rican, etc.) American Indian 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Yes, Give Specify 3 Widowed 4 Divorced "natural". 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) work done during most of working Tuse retired) al Hygiene. econdary (0-12) n and Mental P Department of Health a Important: If Itsm 27 is any Injury or other tra 5 ☐ Other (Specify) 21. Signay of F Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, by Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No After this certificate has 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Certification: To 1 Tes 2 X No 1 Inpatient 2 ☐ FR/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No after death. investigation filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai (Check only one) 29b. Signature and Iffle of certifier 29d. Date signed (Month, Day, Year) Sicien 30. Name and address of person who completed cause of death (Item, 23a) (Type, Print) OU 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar ANSAL.

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygien) 16 35268 For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 11:05 A^M 2006 Nov. 6 Dorothy D. moehlau /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Catonsville

Vear | If Under 24 Hrs. Charlestown Care Center Baltimore 8. Date of Birth (Month, Day, Jan. 17 Birthplace (State or Foreign Country) If Under 1 Year Months Days 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 M 2 F Hours 90 Ï916 New Jersey Director 125-10-8779 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Depertment of Health and Mental Hyglene. Important: If item 27 is marked other then "natural", or items 23s or 28s-1 show any Injury or other traumatic event, the Medical Examinat must be notified at once. 1 ☐ Yes 2X No Director MD Baltimore Catonsville 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 711 Maiden Choice Lane 21228 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 🏖 No Specify: Specify Š 3 XWidowed 4 ☐ Divorced white white Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Harvey Drew 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 308 Pinewood Ave. Silver Spring, MD 20901 Drew Moehlau - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Nov. 7, 06 Baltimore, MD 21. Signatur of Funeral Service Lice ²² Name and Address of Facility
Cremation Society of Maryland, Inc.
299 Frederick Road Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death The pur Tember Immediate Cause (Final disease or condition resulting in death) son oneen **Physician** /Medical Due to (or as a consequence of): Examiner whom Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner death certificate be executed burial-transit Due to (or as a consequence of): ed by the attending physicien detached for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown ۵ The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by page 2 should be asulu Ku 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 1 Yes 2 No certificete 1 Yes 2 No Vital ttending Physician: director, 25. Was case referred to medical Be 26. Place of Death Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To this ō After th 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1- Natural 5 Pending 1 Yes 2 No death investigation 2 Accident within 24 hours after death To the Funerel Director: , completely filled in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ò t 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the nause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. Liçense number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 20040 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Muy MA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 8 2006

DHMH 17 Rev 1/2001

Registrar

			For State Registrar	State	of Marylar		artment of H		nd Mental Hy	giene 2006	35269	
ľ		9	Decedent's Name (First, Middle	e, Last)				204117	2. Date of De	ath	3. Time of Death	
*	Physici Medi		Betty J. May	berry					Month Novemi	Day Yea	ır	
	Examir		4a. Facility Name (If not institution	n, give street and n	umber)		4b. City, Town, or	Location of E		4c. County of De		
	· · · · · · · · · · · · · · · · · · ·		Suburban Hos		1		Bethes			Montgo	mery	
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🛣 F	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hours	Min. (Month, Da	y, Year)	Birthplace (State or Foreign Country)	
į.	Director		233-62-6370 Usual Residence of Decedent		69	115.			Aug. 21	l, 1937 We	st Virginia	
	yland now at		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation				10d. Inside City Limits	
	a-fsl	ctor	Maryland Montg	omery	К	ensing	ton				1 ☐ Yes 2 No	
	ith the	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of What	Country?	
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at		11202 Orleans				20895			United St	ates	
	er de items ner n	une	11. Marital Status 1 ☐ Never Married 2 ☑ Marr	Armed F	cedent Ever in U	.S. 13. \	Nas Decedent of Hi f Yes, specify Cuba	spanic Origin n, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)	14. Race - An Black, Wi	nerican Indian, nite, etc.	
36	ırs aft xaml	by Funeral	3 ☐ Widowed 4 ☐ Divorced	If Yes, G	2 🔼 No live Dates:		I∐Yes 2⊠No	Specify:		Specify:	Thite	
ğ	2 hou	Completed	15. Deceden	's Education		16a. Deced	lent's Usual Occupa	ation		16b. Kind of Busines		
2	thin 7 ie. an "r Med	nple	(Specify only higher Elementary/Secondary (0-12)) (1-4or 5+)	(Give life. L	kind of work done o OO NOT use retired,	luring most of)	working		,	
7	ed wi ygien ner th t, the	Con	12			Ma	anager			Restaura	ant	
and	m - 0 9	Be	17. Father's Name (First, Middle,	,					Name (First, Middle,	,		
₹	hould d Mei marke matic	오	Frank M. McGla: 19a. Informant's Name/Relationsl			405 Mailion	- 1-1-1		ie Dolinge			
<u>s</u>	nd 2 s Ith an 27 is i		Clarence D. Ma		ahand					er, City or Town, State		
ē,	s 1 ar f Hea item 2		20a. Method of Disposition	yberry/nu	20b F	Place of Disno	sition (Name of		ensington,	MaryLand 20c. Location - City of	20895	
Baitimore, Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic evonce.		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 🖾 Other (S	3 □Removal from Decify) Entomon	State Ro	selawn Gar	natory or other place Memorial lens	9) No	vember , 2006	-		
alti	rmit. partin porta y Inju ce,		21. Signature Funeral Service			22	. Name and Addres	s of Facility	Robert_A.	Pumphrey I	, West Virginia Funeral Home/ Consin Avenue	
n —	8 3 E 8 8	5 6	- Mil	- Lau	M00	803 B	ethesda, l	Maryla:	nase, inc. nd 20814-	/55/ Wisc ·3501	consin Avenue	
	4		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximately									
	Physician		Immediate Cause (Final disease or condition resulting in death)		Onset and Death 2 Weeks							
	/Medical Examiner		resulting in death)		(or as a conseq		11					
i.		e.	Sequentially list conditions,	D.	chemic (nyopathy				10 Years	
	ansit and	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			,						
ر ح	an an rial-tr	Exa	resulting in death) Last	Due to	(or as a consequ	uence of);						
8/20	ificate be executed g physician and as the burial-transit	dical		d			<u></u>					
0	ertific ling pl e as t	au i	IF FEMALE:			•		_				
X Q	death certifi e attending d for use as	sician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	tcome pf pregna birth 2 □ Feta	I death 3 🗌	Ectopic pregnancy			23d. Date of de Month	elivery Day Year	
j.	w requires that the death certifit been signed by the attending p should be detached for use as	ysic	1 Yes 2 No 9 Unknown	9□Unkn	nant at time of delown	eath 5∐	Other (specify)			Worth	Day Teal	
7	that ned by deta	/ Phys	Part II. Other significant condition	ns contributing to d	eath but not resu	ulting in the un	derlying cause give	n in Part I.	23e. Did tol	bacco use contribute	to the cause of death?	
Records,	requires that the een signed by the	Completed by	Embolic Cereb	covascula	r Accide	ents			1 📉 Y	es 2∐No 3∏F	Probably 4 ☐Unknown	
D D	law re as bee 2 sho	plete							24a. Was a	n 24b. Were a	utopsy findings available	
	sician: The law certificate has b irector, page 2 s	E							— autops perfori 1□ Yes	sv prior to	completion of cause of	
N Ed	cian; ertific sctor,	Be	25. Was case referred to medical examiner?					26. Place of [Death (Check only on		3 2 10	
	Physician; rthis certific ral director,	٥.	1 ☐ Yes 2 No			ER/Outpatient		4 LI NUISIN		ence 6 □Other (Spe	ecify)	
vision or	ding h. After funer	ion	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investig		of Injury oth, Day Year)	28b. Time of Injury	28c. Injury Work? M 1 □ Y	at ? es 2 □ No	28d. Describe ho	w injury occurred		
2	Attending or death. ector: After by the funer	fica	3 ☐ Suicide 6 ☐ Could n	ot be 28e. Place	of injury - At ho	me, farm, stre		es Z INO	28f Location (St	reet and Number or F	Pural Pouto Number	
5	s after	Certification:	4 ☐ Homicide determin	buildi	ing, etc. (<i>Specify</i>)	, ,,		City or Town	n, State)	urar noute Number,	
			29a. Certifier 1 A Certifying	Physician: To the	best of my know	wledge, death	occurred at the time	e, date and pl	ace, and due to the co	ause(s) and manner a ate and place, and du	s stated.	
	the thin 2, the mplet	Medical	one) 29b. Signature and title of certifier	and man	ner stated.							
	7 ½ 5 8		Michael	a 1110	aterna	- M.I	29c. License		2	9d. Date signed (Mon	th, Day, Year)	
	,5	-	30. Name and address of person v					+) T		November 6	, 2006	
	1		Michael A. West		,	, , , , ,	*	singto	n. Marvla	nd 20891_	2316	
	Stat		31. Date filed (Month, Day, Year)	32 🗜	Lagietrar'e Cianat	uro			.,		-510	
	Registra	r	NOV 0 8	2006	Bus R	K Light	WED .					

ORIGINAL

.) be at time in place inde	indie ink. Ensure An Copies Are Legiple.
State of Maryland / Departr	ment of Health and Mental Hygien 2005

		1 - For State Registrar	State of Maryla	and / Depa	artment of F	lealth and Death	Mental Hygie		35270
Physic		Decedent's Name (First, Middle, Last) Rosemary Lennor					2. Date of Death Month October 29		3. Time of Death 9:00 A M
/Med Exam		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or			4c. County of Deat	
Funera	1	Manor Care Chevy Chas 5. Social Security Number 6.	7. Age (In yi	s. last birthday)	Chevy C If Under 1 Year Months Days	hase If Under 24 Hr. Hours Min		Montgome 9. Birth	nplace (State or Foreign
Directo		578-46-2640 Usual Residence of Decedent	M 2 X 0 F 80	O Yrs.	Worth's Days	Mours IVIII	Nov. 24, 1	944=	ington, D.C.
e Marylan la-f ehow	ctor	10a. State 10b. County Maryland Montgome		city, Town or Lo Bethesda					10d. Inside City Limits 1 ☐ Yes 2 No
with the	Director	10e. Street and Number			10f. Zip Code			Citizen of What Co	•
BAITIMOFE, MARYIANG 21213-UU36 permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-1 show eny injury or other traumatic event, the Madical Examinar must be notified at an once.	by Funerai	4504 Avondale Sti 11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		20814 Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 XNo			Inited Sta 14. Race - Amer Black, White Specify:	ican Indian,
Z15-UC hin 72 hou e. natura Medical E	Completed	15. Decedent's Educify only highest grade	cation	16a. Deced	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of wo	orking 16b	. Kind of Business/I	
filed wit Hygiene other the	Com	17. Father's Name (First, Middle, Last)	4	I	Reception			Real Esta	ite
Maryland 21215-0036 d 2 should be filed within 72 hours at th and Mental Hygiene. 77 is marked other than "natural, or traumatic event, tra Madical Exam	To Be	Joseph P. Lennor		TOP NATE		Mary (me (First, Middle, Maid . Wright		
e, Ma 1 and 2 si Heelth an em 27 is ther traur		Jacqueline A. Wil	son/Friend	4400	East Wes	t Highwa	ural Route Number, Cit ay #611, Be Date 20c.		
SAITIMORE, bermit. Peges 1 ar Department of Hee mportant: If Item: nny injury or other ance.		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		30a.a.y, 0.0	sition (Name of natory or other place Crematorium		ember 6	thesda, M	
Dermit. Departr Importa eny inju		21. Signature of Funeral Service License	9 1	Ro	Name and Addres	s of Facility_	eral Home, Be Bethesda, Mar	thesda-Chev	v Chase Inc
Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	- Preu	more	er the mode of dying	g, such as cardia	ive Plelma		Approximate Interval Between Onset and Death
icate be executed physicien and st the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse				nis	seach	
the death certify the attending yithe attending iched for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	Sc. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	tal death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of deliv	ery Day Year
quires that in signed b	þ	Part II. Other significant conditions cont	inbuting to death but not re	sulting in the un	derlying cause give	n in Part I.	23e. Did tobacc	o use contribute to t	
The law require the law require the law require to late the law been simple pege 2 should be a simple to late the late t	Completed						24a. Was an autopsy performed?	prior to co death?	ppsy findings available impletion of cause of
sician: T certificet irector, po	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital:		Othor		ath (Check only one)		
ding Phy th. : After this	tion: To	27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	4 July Nursing H	ome 5 Residence 28d. Describe how in		ý)
al or Attending safter deeth. Il Director: After de in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, stre			28f. Location (Street: City or Town, Sta	and Number or Rura ite)	al Route Number,
To the Hospital or Attending Physician: The law within 24 hours after deeth. To the Funeral Director: After this certificate has a completely filled in by the funeral director, page 2 st	edical	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examina	cian: To the best of my kn er: On the basis of examin and manner stated.	owledge, daath ation and/or invi	occurred at the time estigation, in my opi	, date and place nion, death occu	, and dus to the cause rred at the time, date a	s) and manner as s nd place, and due to	ated. o the cause(s)
To t comp	X	29b. Signature and title of certifier)		29c. License			ate signed (Month,	* ' '
4	1	30. Name and address of person who com	rpleted cause of death (Ite	m 23a) (Type, P	D005			129106	
U		Synitha Bhogur	illi, 1220A	East 5	3000 Re	and Su	it 230 pocs	n nove	021286
Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Redistrar's Sign	ature	and a		/	,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Lorraine Machen 2006 03 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Peninsula Regional medical Cente. WICONICO 2// Year 8. Date of Birth (Month, Day, Year)
Nov. 7, 1921 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Birthplace (State or Foreign Country) **Funeral** Hours 1 ☐ M 2 💢 F Months Days 84 220-30-6594 Director Va. Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location show 10d. Inside City Limits ral", or Items 23a or 28a-f shov Examiner must be notified at Md. Worcester Berlin 1 ☐ Yes 2X No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? death with 11514 N. Dolly Circle 21811 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Iten any injury or other traumatic event, the Me Ical Examiner once. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo White Specify: Completed by Specify 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail Sales 12 yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ruth Roland Steffen Miller George ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2487 Fairway Dundalk Md. 21222 Cathy Moravec Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Nov. 7 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Moreland Cem. Parkville 4 ☐ Donation 5 ☐ Other (Specify) 2006 Signature of Funeral Service License ²²Connelly Funeral Home Of Dun 7110 Sollers Point Rd. 21222 23a. Pag Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** 1 contractor resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner signed by the attending physician and dbe detached for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4 Pregnant at time of death 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Tes cate has been s , page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed Yes 2 No certificate 1□ Yes completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient ၉ 2 ER/Outpatient 3 DOA this 27. Manner of Feath 28a Date of Injury 28b. Time of 28d. Describe how injury occurred orraine Certification: 28c. Injury at Work? To the Hospital or Attending I within 24 hours after death.

To the Funeral Director, After 1 Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier GREG M. TREUTH 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Machen

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 2006

			For State Registrar	State of M	iaryian		partment of F ertificate of			gien e. U Reg. No.	00	332	12
	Dhuoisi		1. Decedent's Name (First, Middle, L	ast)					2. Date of Dea	ath Day	Year	3. Time of Do	eath
	Physici /Medic			Cusker					11.	_\$	06	1=	PM
T.	Examin	er	4a. Facility Name (If not institution, g.)			or Location of Death			nty of Death		
		- Loft	Carroll Hospita		an (In ura	last hirthd		inster If Under 24 Hrs.	0. Date of Bird		Carrol		:
	Funeral Director		5. Social Security Number 6. 219-32-5276 Usual Residence of Decedent	1 M 2 □ F	ge (In yrs. 74	Yrs	Months Days	Hours Min.	8. Date of Birt (Month, Da March 3	n , Year) 10,1932	9. Birth Cou	nplace (State or F untry) MD	·oreign
	aryland show d at	_	10a. State 10b. County		10c. Cit	y, Town or						10d. Inside City 1 ☐ Yes 2	
	8a-f	cto	MD Balti	more	1	Re:	Isterstown						A_110
	vith th	Director	10e. Street and Number				10f. Zip Code			10g. Citizen o		intry?	
	e 23e	rai	504 Cockeys Mi	11 Road 12. Was Decedent	Ever in 11	e 1		21136	andry Vos av Na	14 0	USA	ican Indian,	
Maryland 21215-0036	S should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "naturel", or Items 23a or 28a-f show aumatic event, the Medical Examinar must be notified at	by Funerai	11. Marital Status 1 □ Never Married 2√√ Married 3 □ Widowed 4 □ Divorced	Armed Forces	? No	.3.	3. Was Decedent of I II Yes, specify Cub 1 ☐ Yes 2 📉 No	an, Mexican, Puerto	Rican, etc.)	Spec	lack, White		
0-10	72 ho	ted	15. Decedent's I	Education		16a. De	cedent's Usual Occupive kind of work done b. DO NOT use retire	pation	n.a	16b. Kind ol	Business/Ir	ndustry	
215	thin 7	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life	o. DO NOT use retire	d)	119				
2	or the	Con		4			Value Eng				k & De	ecker	
pu	be filed ital Hygid od other event, I	Be (17. Father's Name (First, Middle, Las	st)				18. Mother's Name	e (First, Middle,	Maiden Sum	ame)		
<u>vla</u>	should tind Meni	2	Joseph O'Connell					Mary Wh					
lar	2 sh and ls m		19a. Informant's Name/Relationship	(Type, Print)			ailing Address (Street						
	1 and Health em 27 Ather tr		Loretta McCusker	Wife	201 5		Cockeys M						
altimore,	permit. Pages 1 and 2 should be Department of Health and Monlar Importent: If Item 27 Is marked eny injury or other traumatic events.		20a. Method of Disposition 1	☐Removal Irom State		emetery, o	sposition (Name of rematory or other pla	сө)	Date	20c. Location	1 - City or T	own, State	
E	ment ment: lury o		4 ☐ Donation 5 ☐ Other (Spec	eify)		risor	Forest V			Owings			
Ball	permit. Departn Importe eny inju		21. Signature of Funeral Service Lice	ensee	·V	^	22. Name and Addre					wn Road	
	20 = 9		Scephen	M. for	YXI	w		eral Home		erstown	n, MD		
			23a. Part1. Enterithe disease, or con shock, or heart lailure. List onl	mplications that cause y one cause on each l	d the death ine.	h. Do not	enter the mode of dyll	ng, such as cardiac o	or respiratory ar	rest,		Approximate Interval Betwe Onset and Dec	en ath
•	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	s a consequ	uence of):	MIM	*				2 DA	75.
	LAdillillei	1	Sequentially list conditions,	b. Due to (or as									
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	s a cons o q	uence oi):							
	ificate be executed g physicien and as the burial-transit	хап	that initiated events resulting in death) Last	c. Due to (or as	a consen	neuce of).							
60,	be e) icien buria					201100 01/2							
68760,	phys the	edical		d					<u> </u>				
O. Box 6	± 0,00	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	l death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	1		1	Date of deliv Month	very Day Yea	ar
) a	that ed by deta		Part II. Other significant conditions	contributing to death t	out not resu	ulting in the	underlying cause giv	ren in Part I.	23e. Did to	bacco use co	ntribute to	the cause of dea	th?
ds,	uires sign id be	d by	CoRo	NARY	A	RT	FRY DI	SEASE	. 1⊡Y	es 2 No	3 🗆 Pro	bably 4 Unk	cnown
Sord	w requir been si should	Completed	0/=			1			24a. Was	245	Were aut	opsy findings ava	allahla
چ لکہ	The leverete has	E D							autop	rmed?	prior to co death?	ompletion of eau	se of
S	lcien: Th certificete ector, pag	e C	25. Was case referred to-medical	1				26. Place of Death	1 Yes		1 🗆 Yes	2 No	
`3≥	(8)	To B	examiner?	Hospital:	ent 2	FR/Outpa	ient 3□ DOA O#				ther (See	(hr)	
0.2	Phy or this oral d		27. Manner of Death	28a. Date of Inju		28b. Time	ol 28c. Inju		28d. Describe h			19)	
V C ivision	or Attending Fafter death. Director; Atter in by the funer.	Certification:	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		ay Year)	Injur		k? Yes 2 □No					
Sis	tal or Attendir s after death. al Director; Ai ed in by the fu	fice	3 ☐ Suicide 6 ☐ Could not	a 286. Place of in	jury - At ho	ome, larm,	street, factory, office				nber or Rur	ral Route Numbe	r,
≥ á	al or afte I Ollo	ert	4 Homicide	building, e	tc. (<i>Specit</i>)	y)			City or Tou	m, State)			
	Hospit 4 hour Funera tely fills	ledical (29a. Certifier Check only one) Certifying F	Physician: To the best aminer: On the basis of and manner st	of examina	wledge, de tion and/or	eath occurred at the till investigation, in my o	me, date and place, a ppinion, death occurr	and due to the ded at the time, d	cause(s) and r date and place	nanner as s , and due t	stated. to the cause(s)	
	To the To the comple	M	29b. Signature and title of certifier	news			29c. Licens	9246		29d. Date sign	06.		
	87		30. Name and address of person who	completed cause of	death (Item	23a) (Typ	e, Print) Washi'	y Amtis	· West	mins	ter	MDZ	1157
1	Sta	te	31. Date liled (Month, Day, Year)	32. Pogist			1				\		
. *	Registr	ar	NOV 0 8 2	2006	4500	B ,	CONT.						
D	UMU 17 Day 1/0/	201											

State of Maryland / Department of Health and Mental Hygien [] [] 35273 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 5, 2006 **Physician** 2:15 P M Betty Jean Mick /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4080 Madonna Road Jarrettsville Harford 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral^{*} 1 □ M 2 F Days Hours Min 75 235-48-3589 **Director** Sept. 10, 1931 West Virginia Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits , or items 23a or 28a-f show an uner rount be notified at 1 Yes 2 No Harford Director Maryland Jarrettsville 10e. Street and Number 10f. Zip Code 10g. Cîtîzen of What Country? 2 should be filed within 72 hours after death with in and Mental Hygiene. 4080 Madonna Road 21084 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ?7 is marked other than "naturel", o Specify. 3 Widowed 4 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Instructional Assistant Public Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bee Marie Palmer William Lee Barnett 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 siment of Health an ant: if Item 27 is ury or other traus 4080 Madonna Road, Jarrettsville, MD 21084 Charles E. Mick Sr. / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: if any injury or once. 11-9-06 4 Donation 5 10 Other (Specify) Entombment Highview Memorial Grdn Fallston, Maryland 21. Sign up of Funeral Service Licensee McComas Funeral Home, P.A.

50 W. Broadway Street, Bel Air, Maryland 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 000 disease or condition resulting in death) CL /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner sicion and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy jo in the past 12 months?
1 Yes 2 No
9 Unknown 4☐Pregnant at time of death Month Day Year P.O. signed by the a 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 2/2 No 3 Probably 4 Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 1 Yes 2 00 No 1 🗌 Yes After this certification funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 24 hours after deat Funeral Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 | Homicide 29a. Certifier 🛮 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 24 hor To the Fune completely fi 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 82 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 00 32. Registrar's Signature 31. Date filed (Month, Day, Year) NOV 0 8 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend, i.e., 5 per fb. 8861 11-8-06 vt.
State of Maryland / Department of Health and Mental Hygiene 0 0 6

35274 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Frank Nason November 06 2006 12:45 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Elder Care Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 217-66-3989 8. Date of Birth (Month, Day, Year) **Funeral** 1 XM 2 ☐ F Yrs Director 61 11/08/1944 New Jersey Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow the Medical Examiner must be notified at 1 X Yes 2 ☐ No Directo Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 3409 Dudley Avenue 21213 U.S.A. death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after t ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: ģ Specify: Black 3 XWidowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) 12 Machine Operator Machinist Pages 1 and 2 should be filed iment of Health and Mental Hygie ant: If item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Macon Carries Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 2 0 7 Frank Macon Jr. / Son 6726 Townbrook Dr., Apt. B, Gwynn Oak, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of important: If any injury or once. Mt. Zion Cemetery 11/11/2006 Landsdowne, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Surature of Funeral Service Licensee 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Luns CANCES Cokrai /Medical Due to (or as a consequence of) Examiner Eoquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ere brownscul ar Unknee Due to (or as a consequence of). Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached Ö 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 2□ No 1 ☐ Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this After thi 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred To the mosphers after death.
within 24 hours after death.
\ To the Funeral Director: Aft 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0054056 MO 06 30. Name and address of person completed cause of death (Item 23a) (Type, Print) DALJEET 3612 falls 457 B<1+ 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar NOV 0 8 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005

			1 - For State Registrar	State of Maryland / De	epartment of Health and Sertificate of Death	Mental Hygien	006 35275
	Physic /Medi	cal	1. Decedent's Name (First, Middle, Last) GERTUDE L. N.		0.00	2. Date of Death Month Day	3. Time of Death 4: 45 PM
	Examir Funeral Director	ner	2.2 03 0201	ising Home	Months Dave Hours Min	race }	County of Death Ar Lord 9. Birthplace (State or Foreign 17 Maryland
	Maryland I-1 show	tor	Usual Residence of Decedent 10a. State 10b. County MD Harf	ord 10c. City, Town o	Location Havre de Grace		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	th with the 23a or 28a	Funeral Director	10e. Street and Number 415 S. Market	Street	10f. Zip Code 21078	10g. Citize	en of What Country? USA
980	ours after dea rel', or items Examinar mi	þ	11. Maritat Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1	3. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2X No Specify:	to Rican, etc.)	4. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	s 1 end 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other then "naturel", or items 23s or 28s-f show other treumstic event, the Medical Evantical must be conflibed at	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 1 2	Coflege (1-4or 5+)	ocedent's Usual Occupation ive kind of work done during most of wo e. DO NOT use retired) vitchboard Opera	rking	d of Business/Industry Korvette's
yland	should be file and Mental Hy marked othe umatic event,	To Be C	17. Father's Name (First, Middle, Last) Andrew W. Mu	th	18. Mother's Na Gerti	me (First, Middle, Maiden S Cude Iva Bu	Gumame) Ins
	is 1 end 2 sho of Health and I frem 27 is ma other treums		19a. Informant's Name/Relationship (Typ. Joyce Weaver-da	ughter 2610	ailing Address (Street and Number or R) Thorny Drive-(ural Route Number, City or Churchville	Town State Zio Code) ,Maryland 21028
altimore,	permit. Pages 1 Depertment of H Important: If ite eny Injury or ott		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	emoval from State Parkwoo		6-06 Par	ation · City or Town, State kville, Maryland
Ba Ba	Depo impo		23a. Part 1. Enter the disease, or complication of the complete of the complet	15 Fadd	22. Name and Address of Facility EV 8800 Harford Ro Parkville, MD 2	234	EL AND CREMATION SERVICES Approximate
8/60,	Physician /Medical Examiner physician and physician and physician and the prural transit	dical Examiner	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	Due to (or as a consequence of):	Heart Fails	1 US-C	Interval Between Onset and Death
C. Box 6	at the death certific by the ettending p tached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes No 9 □ Unknown		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23	d. Date of delivery Month Day Year
rds, P.	es the		Part II. Other significant conditions cont	ributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use	contribute to the cause of death?
al Records	The law ete has b page 2 sl	Completed		70.		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes Z > No
ion or vital	ing Phys offer this uneral dis	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death Natural 5 Pending investigation	ospitaf: 1 ☐ Inpatient 2 ☐ ER/Outpat 28a. Date of Injury (Month, Day Year) 28b. Time Injury	ent 3 DOA Other: Nursing H	iome 5 Residence 6 28d. Describe how injury of	
DIVISION	ne Hospital or Attendi n 24 hours efter death. te Funeral Director: A pletely filled in by the fo	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of fnjury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street and f City or Town, State)	Number or Rural Route Number,
	To the Hospital or Ai within 24 hours efter of To the Funeral Directompletely filled in by	edical	29a. Certifier (Check only one) TM Certifying Physical Examine	cian: To the best of my knowledge de er: On the basis of examination and/or and manner stated.	ath accurred at the time date and place investigation, in my opinion, death occur	red at the time, date and pl	nd manner as stated. ace, and due to the cause(s)
)	To the within 2 To the complet	Σ	29b. Signature and title of certifier	nD	29c. License number	V	signed (Month, Day, Year)
	2		30. Name and address of person who com	319 S. Union	e, Print) Ave, Haver C	de Grace,	MB 21078
H	Sta Registr		31. Date filed (MoNO) 247, Year 200	32 (Registrar's Signature	beet!		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - State Amend it	em#17,	per FH,	G861,1	.1/8/06	Cer	tificate c	of Dea	th		Reg. No.		
			1. Decedent's Name (First,	Middle, La	st)							2. Date of Dea		Year	3. Time of Death
	Physici /Medio		Mary C. Nic	col								NOVEME			6:40F M
	Examir	er	4a. Facility Name (If not ins						4b. City, Town	n, or Locat			4c. Cou	unty of Death	timore
			Saint Jo						If I Index 1 Va	ar I If Lie	Tows				
	Funeral Director		5. Social Security Number 291–14–1375 Usual Residence of Deced		50X 1□M 2MF	7. Age (In	yrs. last bir 92	Yrs.	If Under 1 Ye Months Da		nder 24 Hrs. urs Min.	8. Date of Birt (Month, Da NOV •	$\overset{\scriptscriptstyle{0}}{1}\overset{\scriptscriptstyle{Y}}{4}\overset{\scriptscriptstyle{Y}}{,}\overset{\scriptscriptstyle{1}}{1}91$	9. Birthp Cour Ohi	place (State or Foreign ntry)
	land ow			County	 	10	c. City, Tow	n or Loc	ation					1	0d. Inside City Limits
	Mary F-f ●h	į	MD Ba	1timo	re		Balti	more	9						1 ☐ Yes 2 🛭 No
	or 28g	Director	10e. Street and Number						10f. Zip Cod	е			10g. Citizen	of What Cour	ntry?
	23a c		7104 Health	field	Road				2121	2			U	JSA	
	tems	Funerai	11. Marital Status		12. Was Dece Armed Fo	rces?	r in U.S.	13. W	/as Decedent of Yes, specify C	of Hispanic uban, Mex	Origin? (Specican, Puerto	cify Yes or No- Rican, etc.)	14.	Race - Americ Black, White,	
21215-0036	be filed within 72 hours after death with the Maryland tall Hygiene. Id other than "natural", or items 23s or 28s-f show event, I'm Medical Enardian must be inclified at	þ	1 Never Married 2[3 Widowed 4 Dr		1 ☐ Yes If Yes, Giv Year or D	A		1	□Yes 2∛ΩI	No Spe	cify: whi	ite	Spe	ecify: whi	te
<u>7</u>	natu	ete	15. De (Specify only	cedent's E highest gra	ducation ade completed)		16a.	Give I	ent's Usual Oc aind of work do O NOT use rea	cupation ne during	most of worki	ng	16b. Kind o	of Business/Inc	dustry
7	within Bne. than	Completed	Elementary/Secondary (0-12)	College (1	-4or 5+)	ш			rirea)			TT-		
0 0	filed Hygid Sther		17. Father's Name (First, A	lidelle, Last)			Onei	naker	18. M	lother's Name	(First, Middle,		me mame)	
Maryland	d a b	To Be	Michael B.	Chuey						Ma	ary Pic	lick			
a S	s 1 and 2 should be if Heelth and Menta item 27 is marked other traumatic e	-	19a. Informant's Name/Re				19b	. Mailing	Address (Stre			l Route Numbe	r, City or To	wn, State, Zip	Code)
	and 2 eelth a n 27 is		Edward Nicol	- Hu	sband		7	104	Health	field	Road	Baltimo	ore. M	D 2121	2
ē.			20a. Method of Disposition 1 ☐ Burial 24 Crem	-4: 0	70	2	Ob. Place of	f Dispos	ition (Name of atory or other)	olace)		ate		on - City or To	
Ĕ	Pages ment of ant: If it ury or o		4 Donation 5 O			State		Cre	ematory			3, 2006		timore	MD
Baltimore,	permit. Page Department important: If eny injury or		21. Signature of Funeral S	1	nsee Lo	m	1	Ci	Name and Ad CEMATIO	dress of F	ciety c	of Maryl Baltimo	Land,	Inc.	0
H			23a. Parti. Enter the dise	ise, or com	plications that c	aused the	death. Do i							ID 2122	Approximate
	Pnysician		shock, or heart failure Immediate Cause (Final	s. List only		-cresing									Onset and Death DAYS
	/Medical		disease or condition resulting in death)	-		or as a co	nsequence	of):							DHID
	Examiner		Sequentially list conditions	- 1	b										
	D #	ner	Sequentially list conditions if any leading to immediat cause. Enter Underlying Cause (Disease or injury			or as a co	usequence	of):							
	and dans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	1	C			-40							
Š,	icate be executed physicien and s the burial-transit		, and an area () and () and ()		000 10 (or as a co	nsequence	or):							
09/89	rtificate ng phys as the	Medicai			_ d										
XOD	attendi for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnain the past 12 months 1 ☐ Yes 2 ☐ No		23c. If yes, out 1⊟Live b 4⊟Pregn	irth 2 🗀	Fetal death		Ectopic pregna Other (specify,				23d.	Date of delive Month	ery Day Year
j.	the y th	hysi	9 Unknown		9□ Unkno	wn									
S,	requires that een signed b hould be deta	by P	Part II. Other significant c	onditions o	contributing to de	ath but no	ot resulting in	n the un	derlying cause	given in P	art I.	23e. Did to	bacco use c	ontribute to th	ne cause of death?
ğ	w require been sig should b	ed										1 🗆 Y	es 2 No	o 3 ☐ Prob	ably 4 □Unknown
ecord	> 0 0	Completed										24a. Was a		4b. Were auto	psy findings available inpletion of cause of
Ĭ	The ate h	ĕ										perfor		death?	2 No
Ital	sicien: certific rector.	Be (25. Was case referred to n	nedical							lace of Death	(Check only or	ne)		1
o = 0	Physicien: this certific ral director.	ဥ	1 ☐ Yes 2 No			3	2 ER/Ou	_	3 DOA		Nursing Hor	ne 5 ☐ Resid	ence 6 🗆	Other (Specif)	1)
	ding h. After fune	ation:		Pending nvestigation	28a. Date o (Mont	of Injury h, Day Yea	ar) 28b. 1	Fime of njury		njury at Vork? □ Yes 2		28d. Describe h	ow injury oc	curred	
DIVISION	P die c	Certification;	3 ☐ Suicide 6 ☐ 0 4 ☐ Homicide	Could not b determined	208. Place	of Injury - ng, etc. (S	At home, fa	rm, stre	et, factory, offic	СВ	2	28f. Location (S City or Tow	itreet and Nu n, State)	umber or Rura	l Route Number,
	ne Hospital or 24 hours afte ne Funerel Di sietely filled in	Medical C	29a. Certifier 12 Ce (Check only 2 Me	rtifying Ph dical Exar	nysician: To the miner: On the ba and mann	isis of exa	y knowledge mination an	death dor inve	occurred at the estigation, in m	time, date y opinion,	e and place, a death occurre	and due to the dead at the time, o	ause(s) and date and plac	I manner as st ce, and due to	ated. the cause(s)
	To the within 2. To the complet	Σ	29b. Signature and title of	ertifier	Ln	M				onse numb			29d. Date sig	gned (Month,)	Day, Year)
	1		30. Name and address of p	erson who	ر حد co pleted caus	e o ceath	(Item 23a) (Type. P		/=400	J0		1000	. 1	2000
	5)= T/	าแรกผ	MARY	AND	21204	
	Sta		31. Date filed (Month, Day,	Year)	05 M. D 32 R	egistrar's S	Signature	Aco	A.			1 17 11 1	not 2 12 Thef	mont on him Tot T	
9,	Registr	ar	NOV C	8 200)6 <i>De</i>	USB S	Asia de								

			For State Registrar	State	of Maryla		artment of H rtificate of		nd Mental Hy	giene Rea. Na	2006	352	277	
574			Decedent's Name (First, Middle,	Last)					2. Date of D	eath		3. Time of	Death	
	Physici		Darlene J. N	eff					Novembe	Day	2006	1:20	P^{M}	
	/Medic Examin		4a. Facility Name (If not institution,		ımber)		4b. City, Town, o	r Location of [4c.				
			Gilchrist Hospi	.ce			Tows	on		Baltimore				
-20	Funeral			. Sex	7. Age (In y	rs. last birthday)	If Under 1 Year	If Under 24	Hrs. 8. Date of B Min. (Month, D	rth	9. Birtho	place (State o	or Foreign	
	Director		203-24-8040	1 □ M 2 🔀 F	73	Yrs.	Months Days	ntry) `						
	P.		Usual Residence of Decedent			A: = .								
	arylar show	_	10a. State 10b. County		100.	City, Town or Lo	cation				1	10d. Inside Ci		
	Ba-f s	cto	MD Baltim	ore	Ti	imonium						1 Tes	2 X 140	
	ith th	Director	10e. Street and Number				10f. Zip Code			10g. Citi	zen of What Cour	ntry?		
	ath w	<u>ra</u>	2120 Folkstone				2109	-			USA			
	r de tems er m	Funeral	11. Marital Status	Armed F		13.	Was Decedent of H If Yes, specify Cub	lispanic Origir an, Mexican, f	1? (Specify Yes or N Puerto Rican, etc.)	0-	 Race - Americ Black, White, 			
36	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Gi	2 ∏ No ive		1⊡Yes 2√∑No	Specify:			Specify: Whi	te		
21215-0036	be filed within 72 hours after death with the Maryland that Hyglene. 3d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d b		Year or E	Jales:		dent's Usual Occu	ation		16h V	nd of Business/In			
45	"na" edlo	Completed	15. Decedent's (Specify only highest	grade completed)		(Give	kind of work done DO NOT use retire	during most o	f working	1		•		
12	filed within Hygiene. Ither than "	Ĕ	Elementary/Secondary (0-12)	College ((1-4or 5+)			urse			ustrial rse	пеатс	1	
	filed Hygi Sther ent, tl		17. Father's Name (First, Middle, La	ast)	<u> </u>			18. Mother's	Name (First, Middle					
Maryland	should be f nd Mental I marked of matic eve	To Be	Elwood K. Shoff					Vei	ra E. LaMo	otte				
ar	short short	ľ	19a. Informant's Name/Relationship	, ,,			-		or Rural Route Num			Code)		
	s 1 and 2 of Health Item 27 I		Gene L. Neff/Hus	band				e Road	Timonium	MD	21093			
Baltimore,	ges 1 t of H if Iter or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	Nemoval from	I	 Place of Dispo cemetery, crea 	sition (Name of natory or other pla	ce) No.	Date	20c. Lo	cation - City or To	own, State		
Ë	್ಕ್ ಕ್ಷರ 4□Donation 5□Other (Specify) Zion Cemete							Nov. 6, 2006 Red Lion, PA						
alt	permit. Departn Imports any inju		21. Signature of Force & Sorvee of	ее			2. Name and Addre	-	D					
ш_			Macka	el J. F1	agle	10	W. Pado	nia Roa	ome of Dul ad Timonii	im, M	D 21083,	inc.		
н			23a. Cart. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Const and Death											
	Physician		disease or condition		co(on c	Ancer					Wel	Jeath کد ACک	
	/Medical		resulting in death)	Due to	(or as a cons	sequence of):								
	Examiner		Sequentially list conditions,	b										
-	ed sit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a cons	sequence of):								
10	cate be executed physician and the burial-transit	хап	that initiated events resulting in death) Last	c	(or as a cons	sequence of):				-				
8760,	be egician	ᄪ			(
387	icate phys the	dical	`	d										
×	eath certifi attending I for use as	Physician/Me	IF FEMALE:	23c. If yes, ou	utcome of pre	anancy				,	23d. Date of delive	201		
Вох	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	. 1 Live	birth 2□F inant at time o	etal death 3	Ectopic pregnanc Other (specify)	у		1	Month		Year	
O.	at the de by the a	ysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□Unkr		or dodan of								
<u>α</u>	The law requires that the death certifi ate has been signed by the attending agge 2 should be detached for use as		Part II. Other significant condition	s contributing to c	death but not i	resulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco u	se contribute to the	he cause of c	leath?	
sp.	uires sign ld be	d by							1 🗆	Yes 2	No 3 □ Prot	oably 4 □l	Jnknown	
Ö	w require been sig should b	ete								e an	24b. Were auto	ney findinge	available	
Vital Records,	The lav	Completed		2,					auto	opsy ormed?_	prior to co death?	mpletion of c	ause of	
a	ician: Th certificate ector, pag		OF Was once referred to medical						1□ Yes	2 No	1 □ Yes	2□ No		
Ξ		Be o	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	I I amakiana O		t 30 DOA Oth	an.	f Death (Check only			LL	1.20	
ŏ		- T	27. Manner of Death	28a. Date		ER/Outpatier	I SI DOX	4 🗆 Nursi	ing Home 5 ☐ Res 28d. Describe			y) (105)	01-	
on	ding F h. After funera	tion	1 Natural 5 Pending 2 Accident investiga	(Mor	nth, Day Year		Wo	rk? Yes 2⊡No			,			
Division	il or Attending after death. I Director; Afte d in by the fune	fica	3 ☐ Suicide 6 ☐ Could no	t be 28e. Place	e of injury - A	l t home, farm, str	eet, factory, office		28f. Location	(Street an	d Number or Rura	al Route Num	nber,	
Dİ.	after I Dire	Certification:	4 ☐ Homicide determin	build	ding, etc. <i>(Sp</i> e	ecify)			City or To	wn, State)			
	spita hours inera y fille	a	29a. Certifier 1 Certifying	Physician: To the	e best of my l	knowledge, deat	n occurred at the ti	me, date and	place, and due to the	e cause(s)	and manner as s	tated.		
	To the Hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the	edical	one)	and mar	nner stated.				occurred at the time			`		
	To To Corr	Σ	29b. Signature and title of certifier	1	1 0	IAAM	29c. Licens	e number	-	29d. Dat	e signed (Month,	Day, Year)		
	i i		1 all Hous	my Yl	ry	1	Da	200		No	vembr	4, 20	26	
-	6		30. Name and address of person w	ho completed cau	ise of death (I	tem 23a) (Type,	Print)	- (+	Roo Pt	M	13,5	16.		
	1		31 Date filed (Month Day Voor)	6-4M	Remetrative Sin	unature 3	The state of the s	- 11	170017	7000		ישק ב		
JA:	Sta Registr	te ar	30. Name and address of person w 31. Date filed (Month, Day, Year)	8 2006	Males	1.	Gosele							

Please Type or Print in Black Indelible lpk. Ensure All Copies Are Legible. amend item 12 per th 9861 11-8-06 vt. State of Maryland? Department of Health and Mental Hygien?

35278 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year NOV 3 2006 GEORGE NOLAN 11:37 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY NATIONAL NAVAL MEDICAL CENTER BETHESDA 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number Funeral 6. Sex Birthplace (State or Foreign Country) 1**X** M 2□ F Yrs. Director 127-26-9096 AUGUST 13, 1933 NEW YORK Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. or 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Ves 2 No MARYLAND MONTGOMERY ROCKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ir then "naturel", or Itema 23s or the Medical Examiner must be r Completed by Funeral 199 ROLLINS AVENUE #511 20852 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1∑ Yes 2 □ No 1952-If Yes, Give Year or Dates: 1980 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 1980 WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) **CLERK** FEDERAL GOVERNMENT of Health and Mental Hygis filtem 27 is marked other r other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 WILLIAM NOLAN CATHERINE KAYNE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 199 ROLLINS AVENUE #511 ROCKVILLE, MARYLAND 20852 TERESA NOLAN/ WIFE 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place)
ARLINGTON
NATIONAL CEMETERY = 5 1

Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: if any injury or once. NOVEMBER 27, 2006 4 ☐ Donation 5 ☐ Other (Specify) CEMETERY 27, 2006 ARLINGTON, VIRGINIA

Name and Address of Facility ROBERT A. PUMPHREY FUNERAL HOME/
ROCKVILLE, INC. 300 WEST MONTGOMERY AVENUE
ROCKVILLE, MARYLAND 20850-2805 22. Name and Address of Facility ROBERT ROCKVILLE, INC. 300 T 21. Signature of Funeral Service Licensee M00335 23a. Part 1. Enter the disease, or obmolications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CORONARY ARTERY DISEASE /Medical Due to (or as a consequence of): Examiner CONGESTIVE HEART FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed use as the burial-transit VALVULAR HEART DISEASE that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medicai BRONCHOGENIC CARCINOMA IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy ρ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) page 2 should be detached 9□ Unknown 9 Unknown 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes 2 X No 1 Tes 2 No Hospital or Attending Physician: After this certific funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 5 Pending investigation 1 Natural 2 Accident within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the } 29b. Signature and the of certific 29c. License number 29d. Date signed (Month, Day, Year) 0101050137 (VA) NATIONAL NAVAL MEDICAL CENTER 1000 30. Name and press of person who completed cause of death (Item 23a) (Type, Print) SUBRATO DEB CDR MC USN
31. Date filed (Month, Day, Year) 32 si strar's Signature State Registrar

			1 - For State Registrar	State of Ma	ryland	-	rtment			and M	-	giene Reg. No.	006	352	79
	Dhuciai	212	1. Decedent's Name (First, Middle, Last)								2. Date of De Month	ath Day	Year	3. Time of	
	Physicia /Medic		Americo Mendes Oliveir								October	11	2006	4:30	a ^M
	Examin	er	4a. Facility Name (If not institution, give str Carroll County Hospital				4b. City, *		niste:				County of Dea rroll	tn	
-	Funeral		5. Social Security Number 6. Sex		(In yrs. las	st birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Bir		9. Birl	thplace (State o	r Foreign
	Director		188-30-3032 1位1	# 2□F	69	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Dec. 27,	1936	Por	tuga 1	
	pu 🛦 🗆		Usual Residence of Decedent 10a. State 10b. County		10c. City.	Town or Lo	cation							10d. Inside Ci	tv Limits
	Aaryla f eho	or	Maryland Carroll			nksburg								1 ☐ Yes	
	r 28a-	Directo	10e. Street and Number				10f. Zip	Code				10g. Citiz	en of What Co	ountry?	
	th with		3038 Brightwell Drive					21	048			United	States	America	
	eme r me	Funeral	11. Marital Status	. Was Decedent E Armed Forces?	ver in U.S.	13. \	Vas Deced Yes, spec	ent of His	spanic Ori	igin? (Spe	ecify Yes or No Rican, etc.)	- 1	4. Race - Ame Black, Whit		
2	filed within 72 hours after death with the Maryland Hygiene. Hygiene. Steel ehow ther than "naturelt, or Itema 23e or 28e-f ehow ent, it e Medical Exandrat must be notified at	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 N If Yes, Give Year or Dates:	0	i	Yos 2			Portu		1	Specify: W	nite	
2-00°	ture!		15. Decedent's Educa			16a. Deceo						16b. Kin	d of Business	/Industry	
<u>ر</u>	hin 72 In "na Medik	Completed	(Specify only highest grade Elementary/Secondary (0-12)		+)	(Give life. L	kind of wor OO NOT us	k done d e retired)	<i>uring</i> mos	t of worki	ing			•	
7	ed with	Com	3	Conogo (1 voi c	'	Carp	enter						me Build	der	
yland	be file ital Hy id oth	Be	17. Father's Name (First, Middle, Last)						18. Mothe	er's Name	First, Middle	, Maiden S	Sumame)		
<u> </u>	nould i Men narke	2	Abilio DeOliveira 19a. Informant's Name/Relationship (Type	Printl	1	10b Mailie	a Addross	(Steadt a			Menedes al Route Numb	or City or	Town State	Zio Codol	
Z Z	id 2 si Ith an 27 ts : traus		Maria Oliveira / Daughte								lle Mar	-		210 0000)	
ē,	s 1 an f Heal ftem 2		20a. Method of Disposition		20b. Pla	ce of Dispo	sition (Nam	ne of	1		Date		ation - City or	Town, State	
Ē	Page nent o int: If iry or		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	_	of He		rioi piao	1	10/16/	2006	Silve	r Spring	g, Maryla	nd
Бапппог	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Meantal Hygiene. I filmportant: If them 27 is marked other than "naturel", or iteme 23a or 28a-f show eny injury or other traumatic event, the Medical Examination must be notified at once.		21. Signature of Funeral Service Licensed Shawn E. Wells	han E	(NU	//	. Name and				Sandy Sp	ring R	load Lauı	rel, MD 2	0707
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused	the death. e.	Do not ent	er the mode	of dying	, such as	cardiac o	or respiratory a	rrest,		Approximat Interval Bet	ween
, 1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	ANTHROSO			IO VAS	CULAR	DISE	ASE				Onset and t	Jeath
	Examiner		Sequentially list conditions b.												
	led Isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	t conseque	nce of):									
	ate be executed hysicien and the burial-transit	xan	that initiated events c. resulting in death) Last	Due to (or as a	conseque	nce of):									
68/6U ,	ysicie	cal	L d.												
	ng phy as th		IF FEMALE:												
X POX	death certifica e attending ph d for use as th	lan/	23b. Was decedent pregnant in the past 12 months?	t ☐ Live birth	2 ☐ Fetal d	leath 3	Ectopic pre					2:	3d. Date of de Month		/ear
	w requires thet the death certificate been signed by the attending phys should be detached for use as the	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of dea	ith 5∟	Other (spe	ecify)						,	
7	thet the	by Ph	Part II. Other significant conditions cont	ibuting to death bu	t not result	ting in the u	ndørlying ca	ause give	n in Part I	l.	23e. Did 1	obacco us	e contribute to	o the cause of d	eath?
ras,	requires thet een signed b hould be deta										10	Yes 2□]No 3□P	robably 4 📜	Jnknown
Hecord	e la hes je 2	Completed									24a. Was	an psy prmed?	24b. Were a prior to death?	utopsy findings completion of c	available ause of
	iicien: The certificete h rector, page	ပိ	25. Was case referred to medical	 					00 81	a of Dooti	1 ☐ Yes	2 🕅 No		2 □ No	
Vital	Physicien: this certific ral director,	To B	examiner?	spital: 1 🖾 Inpatie	nt 2 🗆 E	R/Outpatien	t 3□ DO	Othe		-	me 5□Resi		□Other (Spe	ecify)	
סר			27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y Year) 2	28b. Time of	2	8c. Injury Work			28d. Describe				
<u> </u>	Attending r death.	catle	2 Accident investigation 3 Suicide 6 Could not be				М	101	/es 2 □						
DIVISION	al or At s after d it Direct id in by	Certification:	4 Homicide determined	28e. Place of Inju- building, etc	iry - At horn :. (Specify)	ne, farm, str	eet, factory	, office			281. Location (City or To		Number or R	<i>ural Route Nu</i> m	ber,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical (29a. Certifier 1 Certifying Physic (Check only one) 2 🔀 Medical Examina	cian: To the best of er: On the basis of and manner sta	examination	ledge, death on and/or in	occurred vestigation,	at the tim	e, date ar pinion, dea	nd place, ath occurr	and due to the red at the time,	cause(s) a date and	and manner a place, and due	s stated. e to the cause(s)
	To th To th COMP	Me	29b. Signature and title of certifier				290	License					-	th, Day, Year)	
	٦.		- Jut 17					D0	05192 ⁴	+		Vove	ml of	1,200	00
	10	,	30. Name and address of person who con Herbert Henderson, M.D.	·	•		·	ster.	MD 21	1102					
	Sta	ite	31. Date filed (Month, Day, Year)	32./Registra	r's Signatu	Ire		,							
	Registr	rar	NOV 0 8 2008	De la Cara	D D	Sp	sur!								

		1	For State Registrar	State of I	Marylan		rtment of		nd Mental Hy	/giene Reg. No. 2006	35281
	/siciai	١	Decedent's Name (First, Middle John	le, Last)		Ogde			2. Date of D Month November		3. Time of Death 1:20PM M
	ledica amine		a. Facility Name (If not institution 1113 West Riv		er)		4b. City, Town	or Location of Shington		4c. County of Deat Prince Geor	h
Fun			383 05 7188	6. Sex 7. 1 1 M 2	Age (<i>In yr</i> s. 77	last birthday). Yrs.	If Under 1 Year Months Day		Min. 8. Date of Bi (Month, D Sept	irth Yea <i>r</i>) 9. Birth (Cay) 17,1929 MiCl	nplace (State or Foreign unity) 11gan
Maryland	fied at	. -	Usual Residence of Decedent 10a. State 10b. County 10h. Prince	_	10c. Cit	y, Town or Lo	cation t Washi ı	ngton			10d. Inside City Limits 1 ☐ Yes 2 No
th with the	st be not	5	Oe. Street and Number 1113 West River	rview Road	,		10f. Zip Code))744		10g. Citizen of What Co	
136 rs after dea l', or items	xaminer m	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Mar 3 █ Widowed 4 ☐ Divorced	I If Yes, Give	ss? □No Vie	et- '	Vas Decedento fYes, specify Co □ Yes 2 N	uban, Mexican,	n? (Specify Yes or N Puerto Rican, etc.)	o- 14. Race - Ame Black, White Specify White	e, etc.
IOTE, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mantal Hyglene. If item 27 is marked other than "natural"; or items 23a or 28a-f show	Medical E	ered		nt's Education est grade completed)		16a. Deced (Give life. L	lent's Usual Occ kind of work dor OO NOT use reti	ne during most o red)	of working	16b. Kind of Business/	
and 21 d be filed wi	c event, the	ng ng	12 17. Father's Name (<i>First, Middle,</i> Clair H.			LL.	Col.(Ret	18. Mother's	s Name (First, Middle 1een H. B	e, Maiden Surname)	rorce
Maryland and 2 should alth and Mer 27 Is marke	r traumati	<u> </u>	19a. Informant's Name/Relations Peter S. Ogder	ship (Type. Print)			= '			ber, City or Town, State, 2	
Baltimore, permit. Pages 1 ar Department of Hee mportant: If item	ury or othe		20a. Method of Disposition 1 ∰Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (3	3 □Removal from Sta	0	Place of Dispo cemetery, cren Mary	sition (Name of natory or other p S Churcl	n Cem	ov. 4, 2006	20c. Location - City or Piscatawa	
Baltimo permit. Page Department o	any Injury once.		21. Signature of Funeral Service	120	2015	3 66	33 Old Al	exandria	Ferry Road (l Home, Inc. Clinton, Maryla	
Physic /Med		Ì	23a. Párt1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	a.	fente	My	ocar dia	lying, such as ca	forcum	arrest,	Approximate Interval Between Onset and Death
Exami	ner	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	as a conseq	won a	ny	typ	tensein	researe	
58760, cicate be executed physician and	burial-transit	Exam	cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or	as a conseq	juence of):	yes true	this	lung &	researe	
Box (ath certif	or use a		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		h 2□Feta nt at time of c	Ectopic pregna Other (specify)			23d. Date of del Month	ivery Day Year	
rds, P.O. I quires that the de n signed by the a	pe q	2	Part II. Other significant condit	ions contributing to dear	th but not res	ulting in the u	nderlying cause	given in Part I.		tobacco use contribute to	
I Recor The law requate has been	page 2 should	Completed							24a. Wa aut per 1∐ Yes		topsy findings available completion of cause of
or Vital F Physician: Th this certificate	director	10 26	25. Was case referred to medical examiner? 1 ☐ Yes No 27. Manner of Death	Hospital: 1 ☐ Inp		ER/Outpatien	C OLI BOX	Other: 4 🗆 Nurs		sidence 6 Other (Spece how injury occurred	cify)
Division or Vital Records, To the Hospital or Attending Physician: The law requires t within 24 hours after death. To the Funeral Director: After this certificate has been signe	in by the funeral	Certification:	1 Natural 5 Pendi 2 Accident invest 3 Suicide 6 Could	ng (Month, igation	Day Year)	Injury ome, farm, str	v	☐ Yes 2☐N	28f. Location	(Street and Number or Ruown, State)	ıral Route Number,
e Hospital	oletely filled	Medical Co			is of examina					e cause(s) and manner as e, date and place, and due	
To th within	comp	Me	29b. Signature and title of certific	er fan(Book	LW)	29c. Lice	D 46	285	November 2	
40+	1		30. Name and address of person Paul Bone , MD	10905 Fort W	ashingt	on Road		Washingt	on Maryland		
Re	Stat egistra		31. Date filed (Month, Day, Year NOV 0	8 2006	istrar's Sign	ature /	parti				

			1 - For State Registrar			Marylar	nd / Depa	artmen rtificate					Reg	ene 3. No. 2	006	35	281
	Physici	an	Decedent's Name (First)									2. Date of Month		Day	Year	3. Time of	
	/Media				iver		-					NOV	2,		2006	9:40	Рм
46	Examir	ner	4a. Facility Name (If not in			iber)		4b. City,		Location	of Death				unty of Death Ltimore		
	-		Catonsvi 5. Social Security Number	6.8		7. Age (In yrs.	last birthday)	If Under		If Under	24 Hrs.	8. Date o	f Birth	Dal			or Foreign
	Funeral Director		577-28-2214 Usual Residence of Deced	, 1 +	□м 2√Д F	82	Yrs.	Months	Days	Hours	Min.	JAN 1	Dav.	^(ear) 1924	Cou	place (State ontry) VA	
	land ow			County		10c. Ci	ity, Town or Lo	cation								0d. Inside C	ity Limits
	Mary Frank	to	MD Ho	oward		E11	licott	City								1 🗌 Yes	2 X No
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. It was 12 is marked other than "natural; or iteme 23a or 28a-f show other traumatic avent; the Medical Exertifications is a notified at	Completed by Funeral Director	10e. Sireet and Number 2511 Westch	nester	Ave			10f. Zip 21	Code .043				100	g. Citizen USA	of Whal Cou	ntry?	
	death	nera	11. Marital Status		12. Was Dece	dent Ever in U	J.S. 13.	Was Deced	ient of H	ispanic Ori	igin? (Spe	ecify Yes o	r No-		Race - Ameri		
9	after or its	T.	1 Never Married 2	☐ Married	Armed For	2 X No		1 ⊡Yes :		Specify:		Hican, etc	.)		Black, White,	elc.	
21215-0036	ural',	d b	3 □ Widowed 4 ▼ D	vorced	Year or Da	ites:			2,74,140	ореспу.				Spi	Whit	e	
5-	72 h	ete	15. Di (Specify only	ecedent's En	ducation ade completed)		16a. Dece (Give	dent's Usua kind of wor DO NOT us	al Occupa rk done d	ation during mos	it of work	ing	16	6b. Kind	of Business/In	dustry	
121	within soe.	E D	Elementary/Secondary	0-12)	College (1	-4or 5+)	Homen		se retired	")wn F	Jomo		
	Hygie Hygie theri		17. Father's Name (First, I	Middle, Last)		nomen	laker	1	18. Mothe	er's Name	e (First, Mi					
Maryland	S should be filed with and Mental Hygiene is marked other than sumatic avent, Ina M	To Be	Melvin R. I									Shamb			,		
ary	should Ind Men	-	19a. Informant's Name/Re	elationship (Туре, Print)		19b. Maili	ng Address	(Street	and Numbe	er or Rura	al Route N	umber, (City or To	wn, State, Zip	Code)	
Ž	and 2		Gail Debaug	gh/Dau	ghter		2505	West	ches	ster	Ave 1	Ellic	ott	City	, MD 2	21043	
Baltimore,	permit. Pages 1 and 2 Deportment of Health a Important: If itam 27 is any injury or other tra ance.		20a. Method of Disposition			20b.	Place of Dispo cemetery, crea	sition (Nan	ne of ther plac	e)		Date	20	c. Locati	ion - City or To	own, Slate	
Ĕ	Pages nent of int: If it iry or o		1 Donation 5 □ Cren				. John'				11/6	/06	F	Ellic	ott Ci	tv. MI)
alti	permit. Depertn Imports any inju		21. Signature of Funeral S	Service Licer	C. To	dd Drin	10 2	2. Name an	d Addres	s of Facili	ty					-,	
<u>m</u>	89 5 8		107	MA	2)			cNabh						ME	21228		
			23a. Part1. Enter the dise shock, or heart failur	ase, or com	nlintions that ca one cause on ea	aused the dea ach line.	th. Do not in	e the mo	e of yen	g, such as	carriac	respirato	ry arres	£, 12	21220	Interval Bet	ween
	Physician		Immediate Cause (Final disease or condition	****	a. C	wow	ary	ar	fer	y E	<u>ۍ ژ</u> رخ	eese	.		- 10	Onset and I	Jeath
	/Medical Examiner		resulting in death)		Due to (or as a consec	quence of):										
	Examine:	.	Sequentially list condition	s,	b	or as a consec	77V									× .	
	asit // ed	nine	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury	10 ◀	DO GO	or as a consec	quence oi):										
	al-trai	Examiner	that initiated events resulting in death) Last		cDue to (or as a consec	quence of):										
8760,	The law requires thet the death certificate be executed as been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	cal E		ı	d												
687	ficate p phy.				_ d												
Box	n cert	Physician/Med	IF FEMALE: 23b. Was decedent pregn	ant	23c. If yes, out			7						23d.	. Date of delive	ery	
	death e atte	icia	in the past 12 month 1 ☐ Yes 2 🛈 No	s?	4☐Pregna	nth 2 □Feta antat time of o		∃Ectopic pr ∃ Other (sp					_		Month	Day	Year
P.0	of the by th tache	hys	9 ☐ Unknown		9□ Unkno	wn						-		1			
	res thet signed b	by P	Part II. Other significant of	onditions	contributing to de	ath but not res	sulting in the u	nderlying c	ause givi	en in Part I		23e. l	Did Ioba	cco use	confribute to t	ne cause of d	eath?
Records,	w require been si should I	D e		for	line	to	this	ve_					1 🗌 Yes	2 🗆 N	o 3∏Prob	ably 4 🗹	Jnknown
မင	hesbe ge 2 sh	Completed		<i>'</i>									Was an	2	4b. Were aulo	psy findings	available
H		į										10 Y	pertorme	d2 No	death? 1 ☐ Yes	2□ No	
/ita	hysician: The la nis certificate he: I director, page 2	Be (25. Was case referred to examiner?	medical						26. Place	of Death	h Check o	nly one)	galleron.			
of Vital	Physician: this certificanal director, I	၉	1 ☐ Yes 2 🖫 No] ER/Outpatier			410 110			_		Other (Specif	y)	
ñ	fter file	ë	27. Manner of Death 1 Natural 5 □	Pending	28a. Dale o (Monti	f Injury h, Day Year)	28b. Time o Injury		8c. Injun Worl			28d. Desci	ribe how	injury oc	curred		
Sic	Attending ir death. ector: After by the fune	cat	2 ☐ Accident 3 ☐ Suicide 6 ☐	investigation Could not b				М		Yes 2□	-	20/ 1	10.				
Division	or Al	Certification:	4 Homicide	determined	28e. Place	of Injury - Al h ig, etc. <i>(Speci</i>	nome, farm, sti ify)	eet, factory	r, office				on (Stre r Town,		umber or Rura	il Houte Num	ber,
_	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1NO	ertifying Di	nysician: To the	hast of mult-	owledge door	h occurred	at the ti-	no data a	nd place	and due 1-	the se	50(5)	i manner	tatod	
	To the Hospitel within 24 hours a To the Funeral I completely filled	Medicai	(Check only 2 M	edical Exar	niner: On the ba and mann	sis of examina	ation and/or in	vestigation,	, in my o	pinion, dea	ith occurr	ed at the ti	me, date	e and pla	ce, and due to	the cause(s)
	omple	Me	29b. Signature and title of	certifier	0	AH	end	290	. License	e number		-	290	. Date si	gned (Month,	Day, Year)	
	->-0		> Mules		~~?	, , , ,	MA	1 1	024	694	2		~	over	when.	3,20	06
	6		30. Mame and address of	person who	completed cause	e of death (Ite	m/23a) (Tvpe.	Print)	7	' !	~ /		1		when 2		
	9		15. Turek	hie.	mp 10	509.7	trede	Nick	Ra	. C	afer	yis?	le	, ^	2	1228	
	Sta Regist		31. Date filed (Month, Day NOV 0	8 2006	, 32. Re	egisIrar's Sign	ature										

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 1,03AM Peter Olszewski Jr. NUVEMBER 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner (0) ORIEN KIVERSIDE BELCAMP HARFORD If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Yea Jan. 26, 6. Sex 7. Age (In yrs. last birthday, **Funeral** 87 Hours Year. 1 X M 2 □ F Yrs. Director 221-10-1573 Md Usual Residence of Decedent with the Maryland f show 10a State 10h Counts 10c. City. Town or Location 10d. Inside City Limits or other traumatic event, the Medical Examiner must be notified at Baltimore Dundalk 1 ☐ Yes 2 X No Director Md. or 28a-f 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Items 23a 21222 USA 6801 Brentwood Ave. and 2 should be filed within 72 hours after death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 X Never Married 2 ☐ Married 9 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced 'natural', Completed 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) National Can 8 yrs. Factory Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Peter Olszewski Sr. Elizabeth Holowinski ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau Dolores I. Iozzi niece 6801 Brentwood Ave. Dundalk Md. 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place, 1 XBuriai 2 Cremation 3 Removal from State Nov. Crownsville V.A. Cem. Crownsville ¹ 4 □ Donation 5 □ Other (Specify) 2006 21. Signature of Emaral Service Ligs ^{22. Name and Address of Facility}
Connelly Funeral Home Of Dundalk
7110 Sollers Point RD. 21222 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, short, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to for as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): requires that the death certificate be executed and Due to (or as a consequence of): Box 68760 attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 3 Probably 4 [Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: Sursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 3□ DOA 28a. Date of Injury (Month, Day Year) filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; After 5 Pending investigation 1 Natural death, 1 ☐ Yes 2 ☐ No 2 Accident after death 3 🗌 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) anne 31. Date filed (Month, Day, Year) 12. Registrar's Signature State NOV 0 8 2006 Registrar

SC132510

		•	For State Registrar	State of Maryland / De	epartment of F			ene g. No. 2006	35283
F	Physicia	an	Decedent's Name (First, Middle, Last) GEORGE		OSHER		2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin	_	4a. Facility Name (If not institution, give stre			r Location of Deat	<i>NOV.</i> h	4c. County of De	<u></u>
			Sirai Hospita			fimor			N/A
	Funeral Director		5. Social Security Number 6. Sex 133–05–4702	7. Age (In yrs. last birtho	Months Davs	Hours Min.	8. Date of Birth (Month, Day, 11/0//	1916 9. B	rthplace (State or Foreign NY
	and and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	or Location				10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show rmust be notillised at	tor	MD BALTIMOR						1 ☐ Yes 2 No
	vith the	Funeral Director	10e. Street and Number	F #6	10f. Zip Code	01000	10	g. Citizen of What C	
	ne 234	erai	2 STONEHENGE CIRCL 11. Marital Status		13. Was Decedent of H	21208 Hispanic Origin? (S	pecify Yes or No-	14. Race - Am	USA erican Indian,
	n 72 hours after death with the Marylan "naturel", or items 23s or 28s-1 show adical Examinar must be notilied at		1 Never Married 2 Married	1 A Yes 2 No CUASI	 Was Decedent of H If Yes, specify Cuba Yes 2 √ No 	an, Mexican, Puen Specify:	o Rican, etc.)	Black, Wh	ite, etc. WHITE
2-003e	72 hours after naturel', or ite	ted by	3 🕅 Widowed 4 ☐ Divorced 15. Decedent's Educat	ion 16a. De	ecedent's Usual Occup	pation	1	6b. Kind of Busines	
212	ithin 72 ne. Nen na	Completed	(Specify only highest grade c	College (1-4or 5+)	Give kind of work done fe. DO NOT use retired	during most of world)		DEAL FOTA	·
7 0	be filed within ital Hygiene. Id other then event, the Mar	e Cor	12 17. Father's Name (First, Middle, Last)	BK	OKER	18. Mother's Nar	ne (First, Middle, M	REAL ESTA	IE
/land		To B(JACK	08	HER	MOLLY			(UNKNOWN)
Mar	s 1 and 2 should f Health and Mer ftem 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, RONALD OSHER / SON		Mailing Address (Street D2 LANTANA				
a)	of Heali Item 2 other		20a. Method of Disposition	20b. Place of D	isposition (Name of crematory or other place			Oc. Location - City o	
Baltimo			1 X Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)		RE HEBREW C		6/2006	REISTERS	TOWN, MD
Dall	permit. Pag Department Important: I sny Injury o		21. Signature of Service Licensee		22. Name and Addre			ON & BROS	., INC.
ď			23a. Part1. Enter the disease, or complica shock, or beart failure. List only one	tions that caused the death. Do not					Approximate interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	ITP					Onset and Death
	/Medical Examiner		resulting in peatn)	Due to (or as a consequence of):	•				
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):	:				
_	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):					
8/00,	ate be executed hysician and the burial-transit	ical E	d.					ıl	
٥	artificat ing phy e as th	B	IF FEMALE:						=======================================
POX	death certificate e attending phys d for use as the	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq 1 \) Yes 2 \(\subseteq No \)	If yes, outcome of pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death	3 ☐Ectopic pregnancy 5 ☐ Other (specify)	,		23d. Date of de Month	olivery Day Year
j Ö		hysi	9 🗆 Unknown	9□Unknown					
as, -	law requires that the de as been signed by the 2 should be detached	δ	Part II. Other significant conditions contril	outing to death but not resulting in the	ne underlying cause giv	en in Part I.			robably 4 Qunknown
cords	s been	olete		J 112			24a. Was an		utopsy findings available completion of cause of
ř	The ate h	Completed					autopsy perform 1 Yes 2.	prior to death? DPNo 1 ☐ Ye	_
VItal	Physician: r this certific ral director.	Be	25. Was case referred to medical examiner?	pital:	otiont 20 DOA Oth	or	ath (Check only one		
	ding Phy h. After this funeral d	tlon: To	27. Manner of Death 1. Anatural 5 Pending	28a. Date of Injury (Month, Day Year) 28b. Tim Inju	ne of 28c. Injur	4 🗀 Nursing F	28d. Describe how	nce 6 ⊡Other (Sp. w injury occurred	ecify)
DIVISION	Attending or death. ector: After by the fune	ertification:	a Could not be	28e. Place of Injury - At home, farm building, etc. (Specify)			28f. Location (Streetly or Town,	eel and Number or F	lural Route Number,
5	pital or urs afte eral Diri	O							
	To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one) Certifying Physic 2 Medical Examiner	ian: To the best of my knowledge, do On the basis of examination and/or and manner stated.	pr investigation, in my o	ne, date and place pinion, death occu	rred at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	To the To the comp	ž	29b. Signature and title of certifier	7,	29c. Licens			d. Date signed (Mor	
	8		30. Name and address of person who comp	pleted cause of death (Item 23a) (Tv	(roe Print)	t 5 00	0 /	Ov. 4,	2006
			Wei Xiong, MD	Sinai Hospital o	& Ballimor	e, 240	IW Be	Ivedore,	Ave Baltimore
f.ea	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 8 20	oleted cause of death (Item 23a) (Ty inan (435 2 4a) g 32. Registrar's Signature	Back				IN D 21215

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 35284 Certificate of Death Reg. No. U 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** NoWethber 4, 2006ar James Peterson 1:55 P. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Washington Medical Center Glen Burnie Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 251-38-7273 Months | Days Hours Min 1 M M 2 □ F 75 Director 30, 1931 South Carolina Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shary injury or other traumatic event, the Medical Examiner must be notified. once. Director Maryland Anne Arundel Severna Park 1 √ Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 196 Baltimore Annapolis Blvd. 21146 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 G Yes 2 No If Yes, Give 1948-1949 Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No Specify. \$ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mill Worker Textile 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Raymond Peterson Beulah Richards 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harry J. Peterson/ Son 196 Baltimore Annapolis Blvd. Severna Park, Md21146 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crematory New 7 Odenton, MD 22. Name and Address of Facility Columbia Mortuary Services, Inc. 21. Signature of Fune II Service Li ense P.O. Box 58007 Washington, D.C. 20037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atheroscherotic Heart Disease Physician HRS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner bstructive Pulmonary Diseas Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Candio Vuscular Disease Hypertensive physician and s the buriaf-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical as attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. þ 21 No 3 Probably 4 □Unknown 1 ☐ Yes Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy performed certificate 1 ☐ Yes 2 ☐ No 1□ Yes the Hospital or Attending Physician: hin 24 hours after death. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 2 Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Certification: Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident Director: / Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours at To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) andami

State

KAKESH ARORA

31. Date filed (Month, Day, Year)

NOV 0 8 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD, 14300 GALLANT FOXLN#222 BOWIEMD 20 715

32. Registrar's Signature

ORIGINAL

DHMH 17 Rev 1/2001

Registrar

			Please 1	Type or Print						•		_		
			For 1 _ State	State of Mary	yland						_		0 = 0 0	
			Registrar 1. Decedent's Name (First, Middle, Last)		<i>Ce</i>	rtificate of	Death		Date of Dea		2006	3528 3. Time of Death	5
e la	Physici			, ONES PUGH P	PEARO	CE				Month ovembe	Day	2006 Year	12:43P	
-	/Medio		4a. Facility Name (If not institution, give				4b. City, Town, o	r Location		3 1 01.10 0		County of Dea		
			HOSPICE OF BALTO:		CEN								e County	
L	Funeral		5. Social Security Number 6. Se	x	In yrs. Ia. 89	st birthday) Yrs.	If Under 1 Year Months Days	Days Hours Min. (Month, Day, Year)					thplace <i>(State or Fore</i> buntry) INSY lv ania	gn
	Director		160-16-4582 Usual Residence of Decedent					1		dry r	O, 1	.917 FEI	msyrvania	
	uylanı show dat	_	10a. State 10b. County	10	0c. City,	Town or Lo	ocation						10d. Inside City Lim 1 ☐ Yes 2 🕅 i	
	he Ma 28a-f	Director	Maryland Baltimore	e County			Baltimore			1	10~ Cit	izen of What Co		
	with a or 3 a or 1	μÖ	7005 Wardman Road	1			2121	2			rog. Oil	USA	oundy:	
	hours after death with the Maryland tural", or Items 23a or 28a-f show al Examiner must be notified at	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	. 13.	Was Decedent of H		igin? (Specif	y Yes or No-	.	14. Race - Ame Black, Whit		
9	or ite		1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates:			1 ☐ Yes 2X No	Specify:		,aii, 6(0.)		Specific		
5-0036	hours tural"	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Edu			16a. Dece	dent's Usual Occup	ation			16b. Ki	ind of Business	nite Industry	
	hin 72 e. an "nai Medici	plet	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	\dashv	(Give life.	kind of work done DO NOT use retired	durina mos	st of working				,	
2121	be filed within 72 hours after death with the Marylar Ital Hygiene. do other than "natural", or Items 23a or 28a-f show other, the Medical Examiner must be notified at	Completed		2`		Hor	nemaker					m Resid	lence	
and	I be fill he ded out	Be	17. Father's Name (First, Middle, Last) Sam	Pugh					er's Name (F	ırst, Middle,		_		
Maryland	2 should be and Mental is marked o	ဥ	19a, Informant's Name/Relationship (7)			19b. Maili	ng Address (Street		Lry er or Rural F	Route Numbe		Jones or Town, State, 2	Zip Code)	
	nd 2 27 ls r tra		Clarence E. Pearce	e (Husband)		7005	Wardman	Road.	Balti	more.	Mar	vland 2	1212	
ore,			20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ F		cei	ace of Dispo metery, cre	osition (Name of matory or other plac	ce)	Date	9 1		ocation - City or		
altimore,	Pages tment of tant: If it		4 Donation 5 Other (Specify)		Par		l Cemetery		11/10/				Maryland	
Ba	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licens	awson			2 Name and Addre	ss of Facili Wiede	feld I	Tunera	1 Hc	me, Inc		
			Martin D. Laws 23a. Part1. Enter the disease, or comp	lications that caused the	e death.	Do not en	5500 York ter the mode of dyir	_KOAC ng, such as	, Bali s cardiac or re	LINOTE espiratory ar	rest,	ryland	Approximate Interval Between	
de	Physician		shock, or heart failure. List only o Immediate Cause (Final disease or condition		0	Sis	Syn	doro	me				Onset and Death	
j,	/Medical Examiner		resulting in death)				Syn			-			0.00	
ы	Examiner	<u>_</u>	Sequentially list conditions,	b. Due to (or as a c	Poseque	ence of):	tion p	ne	- may	NA			welle	
	uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that injitated events		y S	1	AgiH						Jen	
90,	oe executed cian and ourial-transit		resulting in death) Last	Due to (or as a c			, -						1000	
6876	The law requires that the death certificate be executed the has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	dical	•	d	ev	nen	tea						J	
9 X	certific ding p	Physician/Medica	IF FEMALE:	23c. If yes, outcome pf	pregnan	ICV						23d. Date of de	livor	
Box	death a atter d for u	iciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐Live birth 2 ☐ 4 ☐ Pregnant at tim	Fetal	death 3	⊒Ectopic pregnancy ⊒ Other <i>(specify)</i>	/			'	Month	Day Year	
0.0	w requires that the di been signed by the should be detached	hys	9 ☐ Unknown	9LUnknown										
	res tha	by	Part II. Other significant conditions co	ntributing to death but n	not result	ting in the u	ınderiying cause giv	en in Part I	l.	23e. Did to		-	the cause of death?	
Ö	requi	Completed												
æ	he law e has ige 2 s	dmo									sy rmed?	death?	utopsy findings availat completion of cause o	f f
ta		Be Co	25. Was case referred to medical					26. Place	e of Death (C		2 ☐ No ne)	1 ☐ Yes	2□ No	_
Division or Vital Records,	nysici nis cer I direc	To B	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 □ E	R/Outpatie	nt 3□ DOA Oth					6 ⊡Other (Spe	city to space	,
o uc	ing P		27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of Injury (Month, Day Y	ear)	28b. Time o Injury	Wor			d. Describe h	now injur	y occurred		
<u>ISI</u>	death ctor: y the	ficat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of injury	- At hom	ne, farm, st		Yes 2□		. Location (S	Street an	d Number or Ri	ural Route Number,	
<u> </u>	al or / s after al Dire	Certification:	4 ☐ Homicide determined	building, etc. ((Specify)					City or Tou	vn, State)		
	Hospit 4 hours Funers ely fille		(Check only 2 Medical Exam	rsician: To the best of ri iner: On the basis of ex	ny know kaminatio	rledge, dea on and/or i	th occurred at the til	me, date a	nd place, and ath occurred	d due to the at the time,	cause(s)	and manner as	s stated. e to the cause(s)	
	To the Hospital or Attending Physician: The within 24 hours after fleath. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	one) 29b. Signature and title officertifier	and manner stated			29c. Licens	e number			29d. Da	te signed (Mont	h. Dav. Year)	
	F » F ö		1 M Knth	of Stiles	, n	D	02	520.	5		No	venber	3,2006	
	10		30. Name and address of person who c			23a) (Type	Print) 0 0	11	0	01		/ >	3,2006	
	1		31. Date filed (Month, Day, Year)	CBM (670 Signatu		· that	- 40	· Ha	V10.7	mo	1 61	04	
	Sta Regist		NOV 0 2006	32. negistrar s	A Signate	Conse								

State of Maryland / Department of Health and Mental Hygien [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** OCTOBER 31, 2:30 a M 2006 ISAAC PRINCE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL CENTER CHEVERLY 8. Date of Birth (Month, Day, Year) March 24 1951 Birthplace (State or Foreign Country)
____ 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number **Funeral** Min Months Days Hours **2** M 2 □ F S.C. 55 Director 577-70-3640 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b Counts "natural", or items 23a or 28a-f show 1 XYes 2 No Director Greenbelt Md. Prince George's 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20770 9147 Edmonston Terrace death Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or iter 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced al Hygiene. d other then "natural svent, the Medical E 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Private Laborer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Willie Fullwood Otis Prince 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 is other tra 11210 Fruitwood Dr. Bowie, Md. Lannie Prince / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Depertment of H Important: If ite any injury or ot once. 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State 11-7-06 Clinton, Md. Resurrection Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) re G Funeral Service License 22. Name and Address of Facility 21. Signatur Capitol Mortuary, Inc. 1425 Maryland Ave., NE Wash., D.C. 20002 Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Parl 1. Enter the disease, or complications that caused the dear shock, or heart failure. List only one cause on each line. Immediate Cause (Final 4 YEARS Physician END STAGE DILATED CARDIOMYOPATHY disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 6-7 YEARS MULTIVALVULAR HEART DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Dav 4☐Pregnant at time of death 5 Other (specify) P.O. I the 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, page 2 should be 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2**X** No 1 ☐ Yes 2 X No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 XInpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 ☐ Yes 2 📉 No this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After t 1 Alatural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) the 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifie WHE MD060244 Nov. 7, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RIVERDALE, MD. 20737 HENRY C. FRONC, 6504 KENILWORTH AVE. JR., M.D. 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar NOV 0 8 2006

06-08276 Craig Preston

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

	F	- For State Registrar	Cert	ificate of	Death			Reg	No. 2	nna	3528
Physicia Medical Examii	1.14	1. Decedent's Name (First, Middle,Last) Craig Preston						ate of Death onth [ovember 1	Day 1	rear	2051 hrs
		4a Facility Name (if not institution, give	street and number)	4	b. City, Town, o	r Location of		370111001		ty of Death	
	4	St. Agnes Hospital 5. Social Security Number 6. Sex	7. Age (In yrs las	ot highday)	Baltimore If Under 1 Yes	ar If Under	24Hrs 8	Date of Birth	(MAN/DDAY	VVI a Ridh	place (State or Foreign
Funeral Director		220-84-8469 1X	M 2 F	35 Yrs.	Months Day		Min.	11/01/		Cour	
any	-	Usual Residence of Decedent 10a. State 10b. County	10c. City, 7	Town or Location	on						10d. Inside City Limits
Maryland 28a-f show	ĕ	MD				imore Ci	ty	,			1 Yes 2 No
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shomatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 412 Mt. Holly	Street		10f. Zip Code	21229		10g		What Counti USA	у?
th with tems 23	Funeral	11. Marital Status 1 X Never Married 2 Married	12. Was Decedent Ever in U.S Armed Forces?		Decedent of Hi es, specify Cuba					nce - America hite, etc.	an Indian, 8lack,
fter dea			1 Yes 2 X No	1 🔲	Yes 2 X No	o specify:			Specif	Black	
hours a	ed by	15. Decedent's Education (Specify onl			's Usual Occupa			done 1	6b. Kind of	Business/Inc	dustry
136 hin 72 e. than "	Completed	Elementary/Secondary (0-12) 12th	College (1-4 or 5+) n/a		Instal	ller			Merced	les Benz	,
5-00 led wit Hygien other		17. Father's Name (First, Middle, Last)				18.Mother's	Name (Firs	t, Middle, Ma			
2121 uld be fil Mental F marked	o Be	Samue 1 19a. Informant's Name/Relationship (Ty	Dermont	Prestor	Address (Stre			e A. S			
, MD 21215-0036 and 2 should be filed within 7 leath and Mental Hygiene. tem 27 is marked other than traumatic event, the Medica	ř	Michelle A. Savage -			Mt. Holly				-		Lip Code)
ore, M es I and 2 of Health If item 2		20a Method of Disposition 1 X Burial 2 Cremation 3		lace of Disposi ematory or oth	tion (Name of ce er place)	emetery,	Da	te	20c. Locatio	on - City or T	own, State
Page nent nent or ot	ļ	4 Donation 5 Other Specify:	Drui		Cemetery		11/07/	2006	Baltin	ore, Ma	ryland
Balti permit Departr Import injury	- 1	21. Signature of Funeral Service Licens			ame and Addres	-		lie Fune			١.
Physician		23a. Part I Enter the disease, or compl failure. List only one cause on eac	cations that caused the death.	Do not enter th	e mode of dying	g, such as car	rdiác or resi	ciratory arres	t, shock, or	heart	Approximate Interval Between Onset and
/Medical ~xaminer			Hepatic steatosis							- 1	Death
		Sequentially list conditions, b									
	Examiner	cause. Enter Underlying Cause	Due to (or as a consequence of)								
recuted and and ransit	Exa	events resulting in death) Last d	Due to (or as a consequence of)								
a a e	/Medical) UNPENDED	AMENDED #23a,27,p	erME, g8	63,1/5/07	TT					
3760, ficate be g physical sthe buri		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregn	ancy		Ectopic p	pregnancy		23d. Date Month	of delivery Da	ay Y ear
ceath certiff	sician	past 12 months? 1 Yes 2 No 9 Unknown	4 Pregnant at time of dea	44	ner (Specify)		p9,				
b.O. Bc that the des ned by the a detached fo	Phys	Part II. Other significant conditions	9 Unknown contributing to death but not re	sulting in the u	nderlying cause	given in Part	t1	23e. Did tob	acco use co	intribute to th	ne cause of death?
P.C.	Š					,		1 Yes	2 🗸 No	3 Proba	ably 4 Unknown
cords, law requir has been s	Completed						أ	24a Was an autopsy	/	prior to co	opsy findings available impletion of cause of
Recoi The law icate has	E O							perform 1 Yes 2		death? 1 ✔ Yes	2 No
ital Rec sician: The s certificate irector, page	B	25. Was case referred to medical examiner?	ospital: 1 Inpatient 2	ER/Outnatient		Other	Check only Nursing Ho		esidence (Other.	
of Vital Recing Physician: The Latter this certificate Funeral director, page	12	1 ✓ Yes 2 No 27. Manner of Death		28b. Time of I		jury at Work?		Describe ho			
sion ttendideath.	atio	1 X Natural 5 Pending 2 Accident Investigation				Yes 2					
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Certification:	3 Suicide 6 Could not be determined		me, farm, stree	t, factory, office	building, etc.	. 281.	or Town, Sta		mber or Rura	al Route Number, City
Hospi 24 hou Funer etely fil		29a. Certifier 1 Certifying Physicis	an: To the best of my knowledg								
To the Hos within 24 h To the Fun	Medical	one) 2 Medical Examiner: 29b Signature and little of certifier	On the basis of examination ar and manner stated	nd/or investigat		on, death occi	urred at the				th, Day, Year)
	~		(V)			M.E.				er 2, 2006	
		30 Name and address of person who o				10.	D 6455	l			
-6		Susan Hogan MD. Assis 31. Date filed (Month, Day, Year)	stant Medical Examiner 22. Registrar's Signatur		n Street, Ba	iltimore, M	21201 טו 				
S Regis	tate trar	NOV 0 8 2006	Jane &	front	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2006 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** November 7, 2006 Barbara Ann Piotrowski 9:25 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct 27, 19 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 □XF 60 218-42-3611 1946 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐No Director Maryland Baltimore Halethorpe 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 5702 2nd. Avenue 21227 **USA** filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 🏋 Divorced "natural" Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygene. Important: If item 27 Is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Social Security State Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harold Fleegle Marie Hanes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Piotrowski, Son 345 Gatewater Court #101 Glen Burnie, MD 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory Inc.: 11/08/06 Baltimore, Maryland 21. Signature of Funeral Service Licensee
Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on earth line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ancer Physician rens /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner A pue The law requires that the death certificate be executed Due to (or as a consequence of): burial-Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 menths? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an certificate has b irector, page 2 sl autopsy performed2 Yes 2 No 1 funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: or Attending 1 Natural 5 ☐ Pending investigation Injury 1 Yes 2 No death. 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifie November 7, 2006

State Registrar

31. Date filed (Month, Day, Year)

6701 BINC 32. Registrar's Signature

NUV 0 8 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

houles St Balto. M6 2120x

Please Type or Print in Black Indelible Ink Brandon Douglas Poe State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day November 5, 2006 1642 hrs **Medical Examiner** BRANDON D. POE 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore County** 4101 Whole Sell Club Drive Fullerton 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Director Aug. 26,1985 Country) Md. 213~15~4997 21 1 X M 2 Yrs Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits AUN 10b. County 1 Yes 2 X No or 28a-f show Maryland Baltimore Perry Hall notified at once with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 21128 USA 8606 Featherhill Rd. 23а Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black death v Armed Forces? White, etc. 1 Never Married 2 Married 2 X No Yes hours after Widowed Divorced If Yes, Give Year 1 Yes 2 X No specify: White Specify: "natural" ģ 16a Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ted 2 should be filed within 72 ho n and Mental Hygiene 27 is marked other than "na matic event, the Medical Ex Elementary/Secondary (0-12) College (1-4 or 5+) Complet Baltimore, MD 21215-0036 N/A Self-Employed Home Improvements 12 yrs. 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Douglas Michael Poe Robin Elaine Beilhart Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 shann nent of Health and ant: If item 27 is Douglas M. Poe (Father) 8606 Featherhill Rd. Perry Hall, Md. 21128 20b. Place of Disposition (Name of cemetery, or other tra 20a Method of Disposition Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Department o St. Peters L. C. Cem. 11-10-06 |Baltimore, Md. Donation 5 Other Specify gnature of Funeral Service Licenses ²² Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** 23a Part I Enter the disease Between Onset and failure. List only one cause on each line /Medical Death Fentanyl Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, ner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Exami (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and The law requires that the death certificate be executed Physician/Medical X UNPENDED attending physician for use as the burial -AMENDED #23a,PII,27,28a-f,perME,g861,11/14/06 TT Division of Vital Records, P.O. Box 68760, IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown the been signed by the hould be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 Yes 2 No 3 Probably 4 Unknown Cocaine use Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has performed? death? ✓ Yes 2 No 2 No 1 🗸 Yes Hospital or Attending Physician: 24 hours after death. 25 Was case referred to medical 26 Place of Death (Check only one) Be examiner? Hospital: 1 Other₄ DOA Nursing Home 5 Inpatient 2 ER/Outpatient 3 Residence 6 V Other Scene this ٩ 1 V Yes No After 27. Manner of Death 28a Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 1 Yes 2 No 5 Pending Fnd 11/5/2006 To the Funeral Director: Fnd 2:05 pm unknown Accident 2 Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be ulerton, MD 4101 Whole Sell Club Dr. determined found in parking lot 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E. November 6, 2006 30. Name and address of person who completed cause of death (Item 23a)

State

Registrar

Carol Allan, MD

31. Date filed (Month Day

Assistant Medical Examiner

8 2005

111 Penn Street Baltimore, MD 21201

			For State Registrar	State o	f Marylan		artment rtificate			and M		gienę Rog. No	200	6	352	90
	Physicia	an	1. Decedent's Name (First, Middle Elizabeth N. Pa	· · · · ·		· · · · · ·					2. Date of De	Day		ear	3. Time of 1210	Death M
	/Medic		4a. Facility Name (If not institution		m <i>ber)</i>		4b. City, To	own, or l	Location o	f Death	Novemb		County of		1210	
			Shady Grove Adv						ville				Mont	47		
	Funeral Director		5. Social Security Number 194–20–5214	6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Months	Days	Hours Hours	Min.	8. Date of Birt (Month, Da April 1	y, Year)	927		lace (State of itry) nsvlva	
and	3		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							1	0d. Inside Cit	tv Limits
Maryi	-f eho	tor		gomery			rwood								1 🗆 Yes	
ith the	or 28e	Oirec	10e. Street and Number				10f. Zip C		_			_	zen of Wh		•	
aath w	ne 23a	Funeral Directo	7300 Muncaster		edent Ever in U.	S 12 1		2085		nin? /500	oilu Vas or No		nited			
after d	or item		11. Marital Status1 ☐ Never Married 2 ☒ Marr	Armed Fo ied: 1 ☐ Yes	rces? 2 🔯 No					, Puerto F	cify Yes or No Rican, etc.)		Black,	White,	etc.	
hours	uraf,	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Gr Year or D	ates:		1 ☐ Yes 2		Specify:	<u> </u>	1	101 10	Specify:		ite	
72 nir	n nat	Completed	15. Deceden (Specify only highes Elementary/Secondary (0-12)		1-4or 5+)	(Give	dent's Usual kind of work DO NOT use	done du retired)	tion uring most	of working	ng		nd of Busir ntgon		Count	V
led with	ygiene her the			5+	401 34)	Te	acher				(5) . ACL II	Pu	blic			
ld be fil	ental H ked otl ic even	To Be	17. Father's Name (First, Middle, John P. Nester	Lasi)							(First, Middle, Habel		Sumame)			
2 shou	and M ie mer aumat	-	19a. Informant's Name/Relations				_				Route Numbe			,		
1 and	Heelth em 27 ther tr		Jocelyn P. Badı 20a. Method of Disposition	eddine / I	20b. P	lace of Dispo	sition (Name	of			oad, De		cation - Ci			J855 ———
Pages	ent of nt: if it ry or o		1 ☐ Burial 2 ☒ Cremation 4 ☐ Donation 5 ☐ Other (S)		State M	emetery, crem ontgom remato	natory or oth	er place) 1	Novem					ary1an	rd
permit	Depertment of Heelth and Mental Hygiene, important; or items 23a or 28s-f show important: if item 27 is marked other than "natural", or items 23a or 28s-f show eny injury or other traumatic event, the Medical Exprired must be multified at once.		21. Signature of Europeral Service	Licensee		433 Ro	Name and ckvil	Address le, le,	of Facility Inc. Mary	Robe 300 land	west M 20850					
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that conly one cause on a	aused the death										Approximate Interval Betw	veen
	ysician Medical		Immediate Cause (Final disease or condition resulting in death)	-a. A	we !	Gocoro	14/	Tok	echo	1					Onset and D	реаш
	aminer		Sequentially list conditions	b	(or as a consequ	ience or):										
pel	K is	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		(or as a consequ	Jence of):										
be execu	physicien and the burial-transit		that initiated events resulting in death) Last	c	(or as a consequ	uence of):										
icate be	physici s the bu	dical		d												
th certif	ending r use æ	an/Me	IF FEMALE: 23b. Was decedent pregnant		come of pregna		Ectopic pred	nancy					23d. Date o		,	
the dea	igned by the attending phys be detached for use as the	Physician/Med	in the past 12 month ? 1 □ Yes 2 □ No 9 □ Unknown		ant at time of de		Other (spec						Month		Day Y	'ear
Bs thet	gned b	by Pt	Part II. Other significant condition	ns contributing to d	eath but not resu	ılting in the ur	nderlying cau	ise giver	n in Part I.				-		e cause of de	
requir	been si	eted	Dementia	11 /											ably 4 □U	
The law	te has hage 2 s	Completed	Ashal Tipol	410							24a. Was autop perfo	sy rmed?	prio dea	r to con th?	osy findings a npletion of ca	ivailable iuse of
Cian:	ertifice actor, p	Bec	25. Was case referred to medical examiner?							of Death	(Check only o			105	ZUPNO	
Physi	r this c eral din	To I	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a, Date	of Injury	ER/Outpatien			4 🗀 Nui		ne 5 Resid)	
ongling in	ath. or: Afte oe fune	atior	1 ☐ Natural 5 ☐ Pendin 2 ☐ Accident investig	g (Mon pation	th, Day Year)	Injury	м	c. Injury Work 1 🗆 Y	es 2 🗹			,	,			
or Atte	after de Directo in by th	Certification:	3 ☐ Suicide 6 ☐ Could (4 ☐ Homicide determ	inad 286. Place	of Injury - At hoing, etc. (Specify	me, farm, str	eet, factory,	office		2	8f. Location (S City or Tow	Street an vn, State	d Number)	or Rura	Route Numb	ber,
UNISION OF VITAL MECONES, F.O. BOX 00100,	within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 completely filled in by the funeral director, page 2.	edicai C	29a. Certifier 1 Certifyin (Check only 2 Medical	g Physician: To the Examiner: On the b	best of my know	wledge, death	occurred at	the time	e, date and	d place, a	nd due to the	cause(s)	and mann	er as st	ated.	
o the	ithin 2 o the l	Med	one) 29b. Signature and title of certifie	and man	ner stated.		00-	1:				10 d D	:	4	S	
-	s ⊢ ō		· (01/3	201			0	213	334			Vove.	nda	2,	2006	
	10		30. Name and address of person	who completed caus	se of death (Item	23a) (Type.	Print)	P		P	kylle,	in A	20.	J	,	
	Sta Registr		31. Date filed (Month, Day, Year)	2806 32	egistrar's Signa	No.		YOG.		1064	VILLES	1942)	5.00	2-X)		

	•	For State Registrar	State of Maryland		it of Health and te of Death	Mental Hygie		35291
Physicia	an	1. Decedent's Name (First, Middle, Last)	Pearson			2. Date of Death Month	Day 5 Year 2006	3. Time of Death 2-20 A M
/Medic Examin		4a. Fecility Name (If not institution, give			, Town, or Location of Deal		4c. County of Deal	3
		5. Social Security Number 6. Sex	2NS NWSING	birthday) If Und	Baltime Brivear If Under 24 Hrs		9. Birt	holace (State or Foreign
Funeral Director			M 2× 46	Yrs. Month		8. Date of Birth Month, Day, Ye	60 M	hplace (State or Foreign puritry)
land ow	-	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Location			-	10d. Inside City Limits
e Mary Sa-f sh	ctor	MD	Ba	Ution	are .			1 Deres 2 □ No
death with the Maryland ms 23a or 28a-f show rithual be rediffed at	Funeral Director	10e. Street and Number	mala Class	10f. 2	21213	10g.	Citizen of What Co	ountry?
death	nera	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Dec	edent of Hispanic Origin? (Secrify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit	
15-UU36 72 hours after death with the Marylan 72 hours after death with the Marylan *naturel', or Items 23e or 28a-f show	by	Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ You If Yes, Give Year or Dates:	1 ☐ Yes			Specify:	act
n 72 ho	Completed	15. Decedent's Edu (Specify only highest grade	cation 16 completed)	6a. Decedent's Us (Give kind of v life. DO NOT	ual Occupation rork done during most of wo	rking 16	b. Kind of Business	Industry
d within giene.	Ошо	Elementary Secondary (0-12)	College (1-4or 5+)	Nurse	7 1 .	w	tea14h	Care
land lid be file lental Hy, ked othe Ic event,	Be	17. Father's Name (First, Middle Last))		18. Mother's Na	me (First, Middle, Mai	den Sumame)	
aryla 2 should and Mer 1s marke aumatic	0	19a. Informant's Name/Relationship (Ty	pe, Print) 1	9b. Mailing Addre	ss (Street and Number or R	ural Route Number, C	ity or Town, State, 2	Zip Code)
Zy alth		Minnie L. Litt	le (Sister) 1	00 04	horidyez	d, Lutte	ville,	W 21093
00		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State	e of Disposition (Netery, crematory of	other place)	Dat6 200	c. Location - City or	M7
Baltimo permit. Pag Department Important: I any injury o once.	İ	21. Signature of Funeral Service License	90	NNOUNT Name	and Address at Facility	denie. Fr	weral	Service
D 8358 D		130 Clato	MO1363	496	5 york	Ed Bal	6 MD 2	1212 Approximate
Dhysician		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.	oo not enter the m	SO I SUCH AS CARDIA	()		Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	Due to (or as a consequence	ce of):	er run	7)		woo Hoully
Examiner	6	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence	DoBulu	l			
cuted	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	:					
cate be executed physician and the burial-transit	dlcal Ex	resulting in death) East	Due to (or as a consequent	ce of):				
	Medic	IF FEMALE:						
COTGS, P.O. BOX to require that the death certifules that the death certifules should be detached for use as	Physiclan/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel dea 4 ☐ Pregnant at time of death	ath 3 ☐ Ectopic			23d. Date of dea Month	ivery Day Year
at the d	hysi	1 ☐ Yes 2 🗹 No 9 ☐ Unknown	9☐ Unknown					
Hecords, P.O. The law requires that the tee has been signed by the age 2 should be detached.	þ	Part II. Other significant conditions con	ntributing to death but not resultin	g in the underlying	cause given in Part I.			the cause of death?
Hecords, he law requires t has been signe age 2 should be o	Completed					24a. Was an	24b. Were au	Itopsy findings available
Of Vital Hec Physician: The lav this certificate has al director, page 2	ошо					autopsy performed 1 Yes 2 C	prior to death?	completion of cause of
Of Vital Physician: T this certificat ral director, p	Be	25. Was case referred to medical examiner?	lospital:		Other	ath (Check only one)		
	7: To	1 ☐ Yes 2 ☑ No 27. Man or of Death	1 Inpatient 2 EHV	Outpatient 3 10 I	28c. Injury at Work?	Home 5 Residence 28d. Describe how		cify)
SION OF	ation	1 ✓ Natural 5 ☐ Pending investigation	(Month, Day Year)	Injury M	Work? 1 ☐ Yes 2 ☐ No			
DIVISION Of It or Attending Physical death. I Director: Atter this din by the funeral di	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, street, facto	ory, office	28f. Location (Stree City or Town, S		iral Route Number,
DIVISION To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical C	29a. Certifier (Check only one)	sician: To the best of my knowled ner: On the basis of examination and manner stated.	dge, death occurre and/or investigation	d at the time, date and placen, in my opinion, death occ	e, and due to the caus urred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
To the within To the comple	Me	29b. Signature and title of certifier	- De 1108	0 3 4 4	9c. License number	29d.	Date signed (Mont	h, Day, Year)
		Muer	, my		D30661	N	ovenne	h, Day, Year)
)		30. Name and address of person who co	ompleted cause of death (Item 23	(Type, Print)	llimole.	Hd - 3	21239	
Sta Registr		31. Date filed (Month, Day, Year)	32. Redistrar's Signature		0 -			
DHMH 17 Rev 1/2		0 0 20	106 Mesure 1	199846				

			1- For State of Maryland / Department of Health and Mental Hygien 2006 3529 Certificate of Death Reg. No.	2
	Physici	an	1. Decedent's Name (First, Middle Last) 2. Date of Death Month Day Year	
	/Medic Examin		4a. Facility Name (If not institution, give street and number) XURS (NG 4b. City, Town, or Location of Death 4c. County of Death	141
			HOMEWOOD GENESIS HOME BALTIMORE	
	Funeral Director		5. Social Security Number 6. Sex 12 - 84 - 83 + 72 Usual Residence of Decedent 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Fore Country) 13 - 43 14 15 15 15 15 15 15 15	aign
	death with the Maryland rms 23a or 28a-f show		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Lim	nits
	Ba-f s	Funeral Director	MD NA Baltimore 1000 20	No
	with the	Dir	106. Street and Number 107. Zip Code 108. Ch Ch Ch Ch Ch Ch Ch Ch Ch Ch Ch Ch Ch	
	death	nera	11. Maritat Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.	
920	permit. Pages I and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If itam 27 is marked othar than "natural", or Items 23a or 28a-f show any injury or othar traumatic svant, the Medical Examinational by multiled at once.	by	1 Never Married 2 Married 3 Widowed 4 Divorced Specify: Armed Porces / If Yes, specify Cuban, Mexican, Puerto Rican, etc.) If Yes, specify: If Yes, specify: If Yes, specify: If Yes, specify: If Yes, specify: If Yes, specify: If Yes, specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Married Specify: Specif	
21215-0036	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry	
12	within iene.	ompi	Elementary/Secondary (0-12) College (1-4or 5+) Course / Corr State of M/)	
	be filed ital Hygie d othar svant, II	Be Co	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)	
Maryland	should b nd Menta marked imatic s	ToE	Halph Purnell Se. 19a. Infoni nt's Name/Relationship (Type, Print) 19b. Mailing Addings (Street and Number on Buyal Route Number, City or Town, State, Zip Code)	<u>_</u>
	1 and 2 s Health an am 27 is othar trau	ť	Rajon Purnell St. (Father) 735 Richuran Ave. By 170. MD 21212	>
Baltimore,	of Head		20a. Mathod of Disposition [Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cametery, crematory or other place) Date 20c. Location - City or Town, State	
ţ	permit. Pages Department of Important: If it any injury or o		"4 Donation 5 Other (Specify) Mt. L'ON (enetery 10-26-06 Buttinore, MD)	
Bal	permit. Departr Importa any inju		21. Signature of Funeral Service Licensee	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of eving such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition METACTATIC CAN (CA) (A) LYNGS Onset and Death	
	/Medical Examiner		Due to (or as a consequence of):	
	Fine!	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. FORLY DIPPLE ENTIRE OF SHUMMOUS COLL Due to (or as a consequence of): CAN CON OF ANUS	
	acuted ind	Examiner	Cause (Disease or injury that initiated events c.	
8760,	icate be executed physiclan and the burial-transit	ai Ex	resulting in death) Last Due to (or as a consequence of):	
687	fficate g physis	edicai	d	
Вох	eath certifi attending I for use as	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 23d. Date of delivery	
0	that the dea led by the att detached fo	Physician/Me	in the past 12 months? 1 Yes 2 No 9 Unknown Month Day Year 5 Other (specify) Unknown	
<u>a</u>	es that tigned by	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?	
ords	w require been sig should b		1 Yes 2 TNG 3 Probably 4 Unknow	٧n
ec	e law ri has be je 2 sh	Completed	24a. Was an autopsy findings availab prior to completion of cause o	ole if
Vital Records,	ician: The certificate ha		performed? death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No	
	ysician: is certific director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 Note: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Loursing Home 5 Residence 6 Other (Specify)	
n of	ding Phy h. After thi funeral		27. Manner of Death 1 Orlatural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 28b. Time of Injury Work?	
Division	ttandi death. stor: A	icati	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be	
<u>.≥</u>	al or A s after I Direct d in by	Certification;	4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	Hospi 4 hou Funer ely fill	edical	29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
	To tha within 2 To the complet	Med	and manner stated.	
	- s + o		PHYSICIAN DOOG 239. OCTOBER 25 200	6
	N I		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR MAN NAIN 4 00 , M.D. M.D.	
	Sta		29b. Signature and tille of certifier ATTONDIN 4 PH 7 SIC(AN DO 06 DO 37. O(TDBCN D5 DXX) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ho ME WOUD GENESIS, 6000 BELLONA AUE BALTIMORE 210 (G) 31. Date filed (Month, Day, Year) NUV 0 8 2006) 1
	Sta Registra	ar i	NUV 0 8 2006 Marie & South	

State of Maryland / Department of Health and Mental Hygiene 2005 For State Ragistrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day 1:15 AM H. Pallen iornelious November 2 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Stella Maris Baltimore ar 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 1.23.1929 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1X M 2□ F Days Hours Min 242 · 42 · 06 83 Usual Residence of Decedent Months Director Yrs. 10a. State 10b. County 10c. City, Town or Location or 28a-f ahow 10d. Inside City Limits and Mental Hygiene. Is marked other than "natural", or Items 23s or 28s-f shov rsumatic event, I'm Medical Examinar must be notified at Baltimore Director handallstow 1 Yes 2 No $\mathbb{Q}\mathbb{M}$ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5107 Old Court Prosed Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 Specify: Black 1 Yes 2 No Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ruck Driver (ransportation) Maryland 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Samuel Puller ၉ Virginia Clanton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health as Important; If Item 27 Is any injury or other traconce. 5107 Old Court Bd Mandallotaun m.D. 21133 Alice V. Pullen/Wife Baltimore, NOVEMBER 20a. Method of Disposition

1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vaugho C. Greene funeral service Arbutus memorial 21. Signature of Funeral Service Licensee 8778 liberty Rd Prandall stam 23a. Part 1. Ends the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** PERIPHERAL VASCULAR DISEASE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consequence of): Examiner sician end The law requires that the death certificate be executed Due to (or as a consequence of). Vital Records, P.O. Box 68760, Physician/Medical the attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy signed by the atte in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 Yes 2 No or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DDA ō HOSPICE 27. Manner of Death 28a. Date of Injury (Month, Day Year) Medicai Certification 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Injury 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗀 Homicide To the Hospital 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) 43725 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. R ar's Signature State NOV 0 8 2006 Registrar

DHMH 17 Rev 1/2001

PULLEN

CORNELIOUS

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2006 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Robert Plociennik 5, 2006 1:55A. November /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Stella Maris Hospice Timonium **Baltimore** If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**⊠**M 2□F 219-30-7377 Yrs. Director July31,1934 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural; or itema 23a or 28e-f show other traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 No Director Md. Howard Ellicott City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12300 Folly Quarter Road 21042-1419 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th 5+ Franciscan Friar Religious Order 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Plociennik Helen Olszak 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21042 19a. Informant's Name/Relationship (Type, Print) Fr. Michael Kolodziei 12300 Folly Quarter Road Ellicott City, Md. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ō = 6 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Sacred Heart of Mary Nov7,2006 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facilit Kaczorowski Funeral Home, PA Tobut phoda 1201 Dundalk Ave.Baltimore,Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** BLADDER CANCER /Medical Due to (or as a consequence ol): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan autopsy performed? Yes 2 No page 1 ☐ Yes 2 ☐ No After this certificate 1 Yes Vital Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: $4 \square$ Nursing Home $5 \square$ Residence 6×10 Other (Specify) $100 \times 100 \times 100$ 1 Yes 2 No ပ 2 ER/Outpatient 3 DOA ð 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; 1 X Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) State NOV 0 8 2006 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 35295 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month V -ICE EARCE 420 PM 2006 /Medical Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death LOSPITAL BACTIMORE N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV. 27,1932 **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) West Virginia Months Days 1 □ M 2017 F Hours Min Director Yrs. 235-48-2723 Usual Residence of Decedent Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic avant, the Madical Examinar must be notified at Director 1 ☐ Yes 2 X No Maryland Baltimore Dundalk death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Itama 23a 7300 Manchester Road 21222 Completed by Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itam any injury or other traumatic avant, the Market. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: 3 ₩ Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Secretary Christian Schools 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Charles Simmons Alma Rains 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeff A. Ervin 1720 Brookview Road (Son) Dundalk, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Donation 5 Other (Specify) Oak Lawn Cemetery 11/6/2006 Baltimore, Maryland 21. Signals e of Funeral Service Lices ee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 140 chedial disease or condition resulting in death) /Medical Due to (or as a conseque Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed use as the burial-transit attending physicien and Division of Vital Records, P.O. Box 68760,< Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month 4☐Pregnant at time of death Day Year 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Onknown 1 Tes 2 □ No peed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 icstre certificate performed 1 ☐ Yes 1 Yes 2 No 2 🖂 No the Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ဥ this 1 Inpatient 2 ER/Outpatient 3 DOA After thi Medicai Certification; 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury death. 2 Accident 1 Tes 2 No Diractor: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after d To the Funaral Diract completely filled in by Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier 29b. Signature and title of certifier 29c-License number 29d. Date signed (Month, Day, Year) 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) BACTINORE NO 21202 AUL PLACE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 8 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year KEED 2006 /Medical 100. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ENCHANTED HILLS KO AD BAITMORE OWINGS 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign Funeral 1**∑**M 2□ F 16 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 🔀 🗸 o Olpry AND 10e. Street and Number 10g. Citizen of What Country? U51 HILLS Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Deves 2 □ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 21215-0036 "natural", or 1 ☐ Yes 2 No Specify þ 3 ☐ Widowed 4 ☐ Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industr (Give kind of work done during most of working life. DO NOT use retired) ייייי אental Hygiene. יי 27 Is marked other than "יי יי traumatic event" Elementary/Secondary (0-12) College (1-4or 5+)
4 4 EARS WEIKEN Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) KEED BERTHA LOUING 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 Is any Injury or other tra once. 2100 MADISON AUG #309 BAIHHORE 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licensee 22. Name and Address of Facility OHAYM AM HAMI TUNUN /Jane 5240 RETS TENSTUN LUAD Halur BAIKMIA, MI 23a. Part1. Enter the risease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart allure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ase or condition resulting in death) Roual **Physician** Lud Disease on Stage /Medicai Due to (or as a conseq ence of): Examiner Hyperrousion Sequentially list conditions, it my cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last consequence of) Physician/Medical Examine The law requires that the death certificate be executed the burial-trai Due to (or as a consequence of): attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death Month Day Year 5 Other (specify) 9 TUnknown certificate has been signed rector, page 2 should be def Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Melline 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1∐ Yes To the Hospital or Attending Physician: within 24 hours after death. ▼o the Funeral Director: After this certification of the funeral Director: After this certification in the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1∐ Yes 2☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

Division or Vital Records, P.O. Box 68760,

Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier Daliah Salahuddi

(Check only

31. Date filed (Month, Day, Year)

29c. License number 29d. Date signed (Month, Day, Year) 11/07/06 D20252

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NO KOAD #101

2006

State Registrar

DHMH 17 Rev 1/2001

			1 - For Stata Registrar	State of M	arylar	nd / Depa	artmen tificate	t of H	ealth ar Death	nd Me	ntal Hygi	ene ₂	006	35297
	Physici	an	Decedent's Name (First, Middle, I								Date of Death	Day	Year	3. Time of Death
	/Media	cal		Roehmer							ctober	31,		
	Examir	er	4a. Facility Name (If not institution, g		1		•	ngsv.	Location of (Death			unty of Deat Balti	
	Funeral			Sex 7. A	ge (In yrs.	last birthday)	If Under	1 Year	If Under 24	Hrs. 8	Date of Birth			hplace (State or Foreign untry)
Ш	Director		216-09-4537	1 XM 2□ F	88	Yrs.	Months	Days	Hours	Min. J	Date of Birth (Month, Day, an. 23,	191	8 Mar	ryland
	and w.		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation	_						10d. Inside City Limits
	Maryl	ţō	Maryland Baltim	ore.			K.	inası	ville					1 □Yes 2X No
	or 28a	lrec	10e. Street and Number				10f. Zip				10	g. Citizer	of What Co	untry?
	eth wi	Funeral Director	11718 Hillside						2108				U.S.A.	
	itema itema ineria	ine	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Armed Forces 1 XYes 2	?	l.S. 13. \	Vas Deced Yes, spec	lent of His ify Cubar	panic Origin , Mexican, F	n? (Specif Puerto Ric	ly Yes or No- can, etc.)		Race - Ame Black, White	
920	urs at	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		I	∏Yes 2	2X No	Specify:			Sp	ecity:	White
21215-0036	within 72 hours after deeth with the Maryland ene. than "naturel", or itema 23a or 28a-f ehow ha Madical Examinar , uat be mulified at	Completed	15. Decedent's (Specify only highest of			16a. Deced	lent's Usua kind of wor	il Occupa	tion uring most o	f working			of Business/	•
121	within ne. than	mpi	Elementary/Secondary (0-12)	College (1-4or	5+)	Maste	OO NOT us	e retired)	•	,			Employ	jed
9	filed v Hygie other t	ပ္ပို့	17. Father's Name (First, Middle, La	st)		maske	i riii		18. Mother's	s Name (F	First, Middle, M	Plumb Jaiden Sui		
an	lid be fental rked o	To Be	John Roehmer						Olga		eiler			
Maryland	should Nand News	-	19a. Informant's Name/Relationship			1	•	•			Route Number,	,		tip Code)
Σ,	end 2 eelth m 27 in	1	Priscilla A. Roc	ehmer (wid							ngsvill			
Baltimore,	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Marylan Depertment of Heelth and Mental Hygiene. Depertment of Heelth and Mental Hygiene. Importent: If item 27 is marked other than "nature!", or itema 23a or 28a-f show imply injury or other traumatic event, the Madical Examination at the notified at DDCs.		20a. Method of Disposition 1 □ Burial 2 X Cremation 3			Place of Dispo cemetery, cren				Date			ion - City or	
Itim	nit. Pa extmer ortent injury	1	4 □ Donation 5 □ Other (Special Service Lice)		Ва	yview (Name an	COLY	of Facility	/2/20 Schi	munek F	unon	more, al Han	Maryland
Ba	Depermine on yis	Ø 19	Bui a-le	elle							timore,			163
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cause ly one cause on each I	d the deat	h. Do not ente	er the mode	e of dying	, such as ca	rdiac or r	espiratory arre	st,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	· Arteni	3 S C	lesti	c Ca	n die	ovas	cula	n Dis	eas	ie	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as										
		er	Sequentially list conditions if any, leading to immediate	bbue to (or as	a conseq	uence of):								
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Ċ										
,092	eath certificate be executed ettending physicien and for use as the burial-transit	i Exe	resulting in death) Last	Due to (or as	a conseq	uence of):								
	cate b physic the b	dicai		d										
Box	death certifica e ettending ph id for use as th	n/Me	IF FEMALE; 23b. Was decedent pregnant	23c. If yes, outcome								23d.	Date of deli	verv
ă	0 0	Physician/Med	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a			Ectopic pre Other (spe						Month	Day Year
<u>Р</u> .	es that the death igned by the ette be detached for	Phys	9 Unknown	9□ Unknown										
ĮS,	The law requires that the ste has been signed by th page 2 should be detache	by	Part II. Other significant conditions	contributing to death t	out not res	ulting in the ur	iderlying ca	ause giver	n in Part I.			accouse o		the cause of death?
Vital Records,	w requir been s	Completed					_				24a. Was an			topsy findings available
Re	ding Physicien: The fav h. After this certificete has funeral director, page 2	dmo						_	-	_	autopsy	ed?	prior to c death?	ompletion of cause of
ital	en: T	Be Co	25. Was case referred to medical						26. Place of	Death (C	1 Yes 2 Check only one	No)	1 Ll Yes	2 No
>	Physicien: this certifice ral director. I	ToB	examiner? 1 Yes 2 □ No	Hospital: 1 Inpati		ER/Outpatien	3□ DO	Othor			5X Residen		Other (Spec	ufy)
n c	ling P		27. Manner of Death 1 Matural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury		Bc. Injury Work?			d. Describe how	v injury od	curred	
Division of	Attending in death.	licat	2 Accident investigati 3 Suicide 6 Could not	be 28a Place of In	urv - At h	ome farm stre	M et factory		es 2 No		Location (Stre	et and N	umber or Rui	ral Route Number,
≦ O	ai or A s effer d Dire	Certification:	4 Homicide determine	building, ei	c. (Specif	y)	ot, lactory,	, 0,1100			City or Town,	State)	2.7.20. 0, 1.0,	a riodio rumpor,
	To the Hospital or Attentwithin 24 hours effer deatl To the Funerel Director: completely filled in by the		(Check only 2 Medical Exa	hywician: To the best	of my kno	wledge, death	encurred t	it the time	data and p	dage, and occurred	dua to the cau	ite(t) and	t manner as	tlated.
	To the He within 24 To the Fu	Medicai	29b. Signature and type of certifier	and manner st	ated.			License						, Day, Year)
	F \$ F 8		1 Libralte N	~ T W	1.					7	1			,
ıĥ	1)	0	37. Name and address of person who	completed cause	leath (It n	n 23a) (Type, I	Print)	טיע	(U)	• (1100	wguu	ושביו	1,2006 93
V	7			Mo, MD	6 ti	ruble	4:11	C	T. Lu	then	sille 1	MN	210	9 3
	Sta Registr		31. Date filed (Month, Day, Year)	32; Registr	ars Signa	iture					,			

Francis Albert Roth, III

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 35298

		1- For State Registrar		Certific	ate of De	ath			F	leg. No.	00	004.
Physici	an/	Decedent's Name (First, Midd	lle,Last)			-			Date of Dea	ath	3. Tin	ne of Death
al Exami	ner	Francis A. Rot	:h III						Month Novembe	Pr 1, 2006	15	11 hrs
		4a. Facility Name (if not institution	on, give street and number)		4b. Ci	ty, Town, c	r Location of			4c. County of I	Death	
		Philadelphia Rd. east	of Raphael Rd.		W	hite Mar	sh			Baltimore	County	
Funeral		5. Social Security Number	6 Sex 7. Age	(In yrs. last bir	thday) If I	Jnder 1 Ye	ar If Unde	er 24Hrs.	8. Date of Bi	rth(MM/DD/YYYY)	9 Birthplace	(State or
Director		214-04-4116	1 X 1 2 F 30		Yrs	onths Da	ys Hours	Min.	Sept.	23, 197	oreign	MD
		Usual Residence of Decedent	I IVI Z		113			لــــــــــــــــــــــــــــــــــــــ	oope.	23, 17,	- Country)	
ru v		10a. State 10b. County		10c. City, Town	or Location						10d I	nside City Limits
Maryland 28a-f show any d at once.		MD Ha	rford	•		erde	212					Yes 2 No
ylanc P-f sh	ţō	10e. Street and Number					-11					100 2 110
Mar r 28g	Director	236 Bush Chape	1 Road		107.	Zip Code	21001			0g. Citizen of What U.S.A		
1715-0036 Id be filed within 72 hours after death with the Maryland fental Hygiene. narked other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at once.							21001			U.S.F.	•	
h wit	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Dec		ispanic Orig				American Inc	lian, Black,
deat or ite	5	1 Never Married 2 M		X No				, Fuerto IXI	carr, etc.)	White, e		
after al",	by F	3 Widowed 4 Div	vorced If Yes, Give Year or Dates.		1 Yes	2 X N	o specify:			Specify:	white	
ours	ᅙ	15. Decedent's Education (Spe	cify only highest grade com	pleted) 16a.	Decedent's Us					16b. Kind of Busin	ess/Industry	1
72 h	Completed	Elementary/Secondary (0-12)	College (1-4 or 5	+)	during most of	working iii	e. DO NOT	use retired	1)			
o3.	E G		2	t	ech sch	001 8	tuden	it		aviation	educ	ation
5-0 Fed w		17. Father's Name (First, Middle	, Last)				18 Mother	's Name (F	irst, Middle,	Maiden Surname)		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Francis A. Rot	h, Jr.				Shir	lev /	A. Bea	ch		
N 3 < E	ဥ	19a. Informant's Name/Relations	ship (Type, Print)	19	b. Mailing Addr	ess (Stre	et and Num	ber or Rur	al Route Nur	nber, City or Town,	State, Zip Co	ode)
MD 2 nd 2 shoul alth and M m 27 is n avmatic		Amanda Strawbr	idge/fiancee	2	36 Bush	Char	el Ro	ad.	Aberde	en, MD 21	001	
e, MD I and 2 shor Health and item 27 is		20a. Method of Disposition		20b. Place	of Disposition (Name of ce	emetery,		ate	20c. Location - Ci	ly or Town,	State
ages nt of othe		1 X Burial 2 Cremation		Highv	tory or other pla iew Mem	• Gdr	is.	11/6	/2006	Fallston	• MD	
ti P		4 Donation 5 Other S										
Baltimore, permit Pages I and Department of Heal Important: If iten		B. C. 116	1001		Schim	unek	Funer	al Ho	ome of	Bel Air,	Inc.	
- Physician	\dashv	23a. Part I. Enter the disease, or	complications that caused	the death. Do no	of enter the mo	Mac	Phail	Roa	Bel	Air, Md.	2101	numeto Intonial
Medical		failure. List only one cause	on each line.		or orner the me	ac or aying	, 30011 63 06	ar diac or re	spiratory arr	est, shock, or heart		oximate Interval veen Onset and
∠xaminer		Immediate Cause (Final disease or condition resulting in death)										Death
		or condition recounting in dealing	Due to (or as a conse	quence of):								
	<u>.</u>	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	difference of).				_				
	Examiner	cause. Enter Underlying Cause		9401100 01).								
=	xar	events resulting in death) Last	Due to (or as a conse	quence of):								
cuted			d									
8760, rificate be executed ng physician and as the burial - transit	n/Medical	UNPENDED	AMENDED									
8760, tificate being physicas the bur	ŝ	IF FEMALE:	23c. If yes, outcom	e of pregnancy		-				23d. Date of de	ivery	
W = E #	an/	23b. Was decedent pregnant in the past 12 months?	I Live birth	2	Fetal dea	ath 3	Ectopic	pregnancy	/	Month	Day	Year
Box e death c the atten	Sici	1 Yes 2 No 9 Uni	coours I	ime of death	5 Other (S	Specify)						
P.O. Box 687 s that the death certific med by the attending p	Physicia		9 Onknown									
P.O es that t igned by	by	Part II. Other significant condit	ions contributing to death	but not resultin	g in the underly	ing cause	given in Par	rt I.		bacco use contribut		
S, P.C.	De la								1 Yes	2 V No 3	Probably 4	Unknown
ords, leading verguines been sig should be	je								24a. Was autop			ndings available on of cause of
ecc ne lav te ha	Completed								perfor	med? deat	h?	
tal Rectian: The certificate ector, page		25 Was case referred to medica				26 Place	e of Death (Chock only	1 Yes	2 No 1	Yes	2 No
of Vital Records, in Physician: The law requir Wher this certificate has been somether director, page 2 should the	Be	examiner?	Hospital: 1 Inpatier	t 2 FR/O	utpatient 3	DOA	Othor	Nursing H		Besidense & De		
of Vi Physical this eral direction	유	1 Yes 2 No 27. Manner of Death	28a. Date of Injur		Time of Injury		iry at Work?			Residence 6 One of the control of t	ther: Scene	
ion of tending Pheath	Certification:	1 Natural 5 Pend	(Month, Day, Ye	ar) 1508	8 hrs		Yes 2	lDr	iver of aut	o involved in co	ollision	
Division tal or Attendir rs after death at Director: A	ξat		stigation									
Divis pital or At ours after d teral Direc filled in by	Ę۱		d not be 28e. Place of Injury		arm, street, fact	ory, office I	building, etc		or Town, S	treet and Number o		-
spita hours fille	3	4 Homicide	(Specify) Loc	al Street				Ph	iladelphia F	d and east of Ra	hael Rd, \	White Marsh,
e Ho n 24 l e Fu	g		hysician: To the best of my									
Division of Vital Records, P.O. Box 6 To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death To the Funeral Director: After this certificate has been signed by the attendi completely, filled in by the funeral director, page 2 should be detached for use	Medical		miner: On the basis of exam and manner stated.	ination and/or i	nvestigation, in	my opinior	n, death occ	curred at th	e time, date	and place, and due	o the cause	(s)
	Σ	29b. Signature and title of certifie	n n	/		29c. Licens	se number			29d Date signed	Month, Day	Year)
			M. 1/4			O.C.	M.E.			November 2,	2006	
, 7	ŀ	30. Name and address of person	who completed cause of de	ath (Item 23a)								
10		Jack Titus MD. Dep	outy Chief Medical Ex	aminer 1	11 Penn St	reet, Bal	timore, N	/ID 2120	1			
St	ate	31. Date filed (Month, Day, Year)	32. Registrar	s Signature	1.11.						_	
Regist		NUV 0 8 2	006 Marian	15. 16	parker							

35299

	ret Rayner ive street and number) RITAN Sex 1 M 2 F 7. Ag 12. Was Decedent Armed Forces? 1 Myes 2 M If Yes, Give Year or Dates: Education rade completed) College (1-4or 5) Eler (Type, Print) Gran 2 Yarworth Premoval from State iffy) ensee	10c. City, To 10c. City, To 10c. City, To 16c. City, T	wn or Location Fall 13. Was D If Yes, 1 D 13. Was D If Yes, 1 D A. Decedent's (Give kind of life DO NO Check 1814 A of Disposition orly, crematory, crematory, cawn Cel 22. Nam 9705	BAL Inder 1 Year Inths Days CSton f. Zip Code 2104 Decedent of H specify Cuba es 2 (X No Usual Occupation of work done of Decedent of H specify Cuba es 2 (X No (Name of or other plac metery e and Address	ispanic Origin? (in, Mexican, Pue Specify: ation during most of w 18. Mother's Na There and Number or F Way, F e)	Specify Yes or Noto Rican, etc.) Specify Yes or Noto Rican, etc.) Specify Yes or Noto Rican, etc.) Same (First, Middle & Kown all & Long all	Day OB 4c. Coun inth Pay, Year 24, 1922 10g. Citizen of U. 10- 14. Ra Bli Speci Manufa Wester e. Maiden Suma Oalski ber, City or Town MD 21 20c. Location	What Courses A. Ice - American America	place (State or Foreintry) YLand 10d. Inside City Limi 1 □ Yes 2 1 N Intry? can Indian, etc. White dustry ng ctric
acility Name (If not institution, ging acility Name) (If not institution, ging acility Name) (If not institution, ging acility Name) (If not institution, ging acility Name) (If not institution, ging acility Name) (If not institution, ging acility Name) (If not institution) (If not	ive street and number) Sex 1 AN Sex 1 M 2 X F That	10c. City, To 10c. City, To 10c. City, To 16c. City, T	wn or Location Fall 13. Was D If Yes, 1 D 13. Was D If Yes, 1 D A. Decedent's (Give kind of life DO NO Check 1814 A of Disposition orly, crematory, crematory, cawn Cel 22. Nam 9705	BAL Inder 1 Year Inths Days CSton f. Zip Code 2104 Decedent of H specify Cuba es 2 (X No Usual Occupation of work done of Decedent of H specify Cuba es 2 (X No (Name of or other plac metery e and Address	If Under 24 His Hours Min Hours Min Mexican, Pue Specify: attion furing most of w. 18. Mother's Na There and Number or F. Way, F. (e)	Specify Yes or Noto Rican, etc.) Specify Yes or Noto Rican, etc.) Specify Yes or Noto Rican, etc.) Same (First, Middle & Kown all & Long all	10g. Citizen of U. 10g. Citizen of U. 10g. Kind of E. Manufa Wester. e, Maiden Surna Oalski ber, City or Towr MD 21 (20c. Location	what Courses Americack, White, (Carrier, Mark What Courses, White, (Carrier, Mark White, (Carrier, Mark White, Mark White, Mark White, Mark White, Mark White, Mark White, Mark White, Mark White, Mark White, Mark White, Mark White, Mark White, Mark White, Washington, State, Zip 247 - City or To	place (State or Foreintry) Yeand 10d. Inside City Limi 1 Yes 2 N Intry? can Indian, etc. White dustry Ing Ctric
cial Security Number 6. 5-18-6785 I Residence of Decedent State 10b. County ryland Harfor Street and Number 1814 Arabian Wallarital Status Never Married Widowed 4 Divorced (Specify only highest gr ementary/Secondary (0-12) 12 ather's Name (First, Middle, Last Ouris Schmuck Unformant's Name/Relationship Cannine R. Cook Method of Disposition Suburial 2 Cremation 3 Edunine Grundle Cause (Final issue) Part 1. Enter the disease, or conshock, or heart failure. List only adiate Cause (Final issue or condition	Sex 1 M 2 M F Trd Trd Trd Trd Trd Trd Trd Tr	10c. City, To 10c. City, To 10c. City, To 16c. City, T	wn or Location Fall 13. Was D If Yes, 1 D 13. Was D If Yes, 1 D A. Decedent's (Give kind of life DO NO Check 1814 A of Disposition orly, crematory, crematory, cawn Cel 22. Nam 9705	BAL Inder 1 Year Inths Days CSton f. Zip Code 2104 Decedent of H specify Cuba es 2 (X No Usual Occupation of work done of Decedent of H specify Cuba es 2 (X No (Name of or other plac metery e and Address	If Under 24 His Hours Min Hours Min Mexican, Pue Specify: attion furing most of w. 18. Mother's Na There and Number or F. Way, F. (e)	Specify Yes or Noto Rican, etc.) Specify Yes or Noto Rican, etc.) Specify Yes or Noto Rican, etc.) Same (First, Middle & Kown all & Long all	10g. Citizen of U. 10g. Citizen of U. 10- 16b. Kind of B. Manufa Wester. e. Maiden Surna Oalski ber, City or Town MD 21 (20c. Location	N/A 9. Birthy Coul Marx What Coul S.A. Ice-Americack, White, We Ele M	place (State or Foreintry) YLand 10d. Inside City Limi 1 □ Yes 2 1 N Intry? can Indian, etc. White dustry ng ctric
cial Security Number 5-18-6785 Residence of Decedent State 10b. County Tyland Harfor 1814 Arabian Wall Initial Status Never Married Specify only highest gr Informant's Name/Relationship Cannine R. Cook Method of Disposition Method of Dispo	Sex 1 M 2 K F 7 Ag 1 M 2 K F 1 M 2 K F 7 Ag 1 M 2 K F 1 M 2	10c. City, To 10c. City, T	inthday) Yrs. If U Yrs. If U Mor Fall 10 13. Was D If Yes, 1 yes 20 An Decedent's (Give kinds of the check) Check 1814 A A Of Disposition of Disposition of Disposition of ye, crematory. 22. Nam 9705	Inder 1 Year Ithis Days Days	If Under 24 Hi Hours Mi Hours Mi 17 Ispanic Origin? (In, Mexican, Pue Specify: ation during most of w 18. Mother's Na There and Number or F Way, F e)	Specify Yes or Noving Specify Yes or North Rican, etc.) Sorking Sa Kow Rural Route Num. ALLS Lon, Date 7/2006	10g. Citizen of U. 10g. Citizen of U. 14. Ra Bli Special 16b. Kind of B Manufa Wester. Maiden Suma Palski ber, City or Towr MD 21 (20c. Location	9. Birth, County Mark What County Mark What County Mark S. A. Idea - Amenicack, White, (if): (Business/In Cturing Electoria Elector	10d. Inside City Limi 1 □ Yes 2 ★ N Intry? can Indian, etc. White dustry ng ctric
I Residence of Decedent State 10b. County TYLAND HATGOR Street and Number 1814 Arabian Walarital Status Never Married 2 Married Widowed 4 Divorced (Specify only highest gromentary/Secondary (0-12) 12 ather's Name (First, Middle, Last Schmuck Informant's Name/Relationship (2016) 2016 Burial 2 Cremation 3 [15] 2017 Burial 2 Cremation 3 [15] 2018 Burial 2 Cremation 3 [15] 2018 Burial 2 Cremation 3 [15] 2018 Burial 2 Cremation 3 [15] 2018 Burial 2 Cremation 3 [15] 2018 Burial 2 Cremation 3 [15] 2019 Burial 2 Cremation 3 [15	1 M 2 N F Trd Trd 12. Was Decedent Armed Forces? 1 Yes, Give Year or Dates: Education rade completed) College (1-4or 5) Cler (Type. Print) gran 2-Yarworth Pemoval from State with) ansee	83 10c. City, To Ever in U.S. No 16 4- 15 4ght) 20b. Place cemet 0 ak L	wn or Location Fall 13. Was D If Yes, Clive kind c inter DO No Check 18.14 A 18.14 A 18.14 A 18.14 A 18.14 A 18.14 A 18.14 A 22. Nam 9705	Poston 1. Zip Code 2104 Decedent of H specify Cuba es 2[X] No Usual Occupation of Work done of Press (Street a rabian (Name of or other place metery and Address	ispanic Origin? In, Mexican, Pue Specify: ation during most of w 18. Mother's Na There and Number or F Way, F e)	Specify Yes or Note Rican, etc.) Specify Yes or Note Rican, etc.) Sorking ame (First, Middle Note Note Rougal Route Note Note Rougal Route Note Note Rougal Route Note Rougal Route Note Rougal Route Note Rougal Route Note Rougal Route Note Rougal Route Note Rougal Route Rou	10g. Citizen of U. 10g. Citizen of U. 14. Ra Bli Special 16b. Kind of B Manufa Wester. Maiden Suma Palski ber, City or Towr MD 21 (20c. Location	What Courses A. Ice - American America	10d. Inside City Limi 1 □ Yes 2 ★ N Intry? can Indian, etc. White dustry ng ctric
State 10b. County Tryland Harfor Street and Number 1814 Arabian Wall Idential Status Never Married 2 Marned (Specify only highest gramentary/Secondary (0-12) 12 Informant's Name (First, Middle, Last Chris Schmuck Informant's Name/Relationship of Burial 2 Cremation 3 Elementary (Specific Companion 5 Other (Specific Companion 5	12. Was Decedent Armed Forces? 1 Yes 2 (X) If Yes, Give Year or Dates: Education rade completed) College (1-4or 5) ELET (Type. Print) Gran 2 - Yarworth Print Gran Removal from State with)	Ever in U.S. No 16 15 deliant 18 deliant 20 20 20 20 20 20 20 20 20 20	Fall 13. Was D If Yes, 1 yes a. Decedent's (Give kind & Check The Check 1814 A 1814 A 1814 A 1819 Add 1814 A 22. Nam 9705	Eston f. Zip Code 2104 Decedent of H specify Cuba es 2 [X] No Usual Occupp of work done of DT use retired et Areas (Street a rabian (Name of or other plac metery ee and Address	ispanic Origin? (in, Mexican, Pue Specify: ation during most of w 18. Mother's Na There and Number or F Way, F e)	ame (First, Middle &a Kow Bural Route Numi allston, Date	IL. Ball Special Speci	What Cour S.A. Ice-America Ice-America Ichy: Ic	1 □ Yes 2 X N ntry? can Indian, etc. White dustry ng ctric Code)
Street and Number 1814 Arabian Walarital Status Never Married 2 Married Widowed 4 Divorced 15. Decedent's E (Specify only highest grannentary/Secondary (0-12) 12 ather's Name (First, Middle, Last Orbris Schmuck Informant's Name/Relationship of Cannine R. Cook Method of Disposition Will Burial 2 Cremation 3 E Donation 5 Other (Specific Indicated Service Lice) Part 1. Enter the disease, or conshock, or heart failure. List only adiate Cause (Final isse or condition)	12. Was Decedent Armed Forces? 1 Yes 2 (X) If Yes, Give Year or Dates: Education rade completed) College (1-4or 5) ELET (Type. Print) Gran 2 - Yarworth Print Gran Removal from State with)	d- dghtr) 20b. Place cemet Oak L	a. Decedent's (Give kind of life Do Not Check) 1814 A A of Disposition of Disposition cry, crematory. CAWN Ce. 22. Nam 9705	f. Zip Code 2104 2204 Decedent of H specify Cuba es 2 (X) No Usual Occupior work done of DT use retired ex Analysis (Street a rabian (Name of or other plac metery ee and Address	ispanic Origin? (in, Mexican, Pue Specify: ation during most of w 18. Mother's Na There and Number or F Way, F e)	ame (First, Middle &a Kow Bural Route Numi allston, Date	IL. Ball Special Speci	What Cour S.A. Ice-America Ice-America Ichy: Ic	1 □Yes 2XIN Intry? can Indian, etc. White dustry ng ctric Code)
Street and Number 1814 Arabian Walarital Status Never Married 2 Married Widowed 4 Divorced 15. Decedent's E (Specify only highest grannentary/Secondary (0-12) 12 ather's Name (First, Middle, Last Orbris Schmuck Informant's Name/Relationship of Cannine R. Cook Method of Disposition Will Burial 2 Cremation 3 E Donation 5 Other (Specific Indicated Service Lice) Part 1. Enter the disease, or conshock, or heart failure. List only adiate Cause (Final isse or condition)	12. Was Decedent Armed Forces? 1 Yes 2 (X) If Yes, Give Year or Dates: Education rade completed) College (1-4or 5) ELET (Type. Print) Gran 2 - Yarworth Premoval from State with) ensee	d- dghtr) 20b. Place cemet Oak L	a. Decedent's (Give kind of life Do Not Check) 1814 A A of Disposition of Disposition cry, crematory. CAWN Ce. 22. Nam 9705	f. Zip Code 2104 2204 Decedent of H specify Cuba es 2 (X) No Usual Occupior work done of DT use retired ex Analysis (Street a rabian (Name of or other plac metery ee and Address	ispanic Origin? (in, Mexican, Pue Specify: ation during most of w 18. Mother's Na There and Number or F Way, F e)	ame (First, Middle &a Kow Bural Route Numi allston, Date	IL. Ball Special Speci	S.A. ice Americack, White, ify: (Business/In Ctwi M. Ele me) 7, State, Zip 047 City or To	can Indian, etc. White dustry ng ctric
larital Status Never Married 2 Married Widowed 4 Divorced (Specify only highest grammentary/Secondary (0-12) 12 ather's Name (First, Middle, Last Schmuck Informant's Name/Relationship (2000 R. Cook Method of Disposition Burial 2 Cremation 3 Elementary (Specific Cook Method of Disposition 5 Other (Specific Cook Method of Funeral Service Lice Part 1. Enter the disease, or conshock, or heart failure. List only adiate Cause (Final Isse or condition	12. Was Decedent Armed Forces? 1	d- dghtr) 20b. Place cemet Oak L	a. Decedent's (Give kind collected of the CR) 1814 A 1814 A 1814 A 1814 A 1817 A 1817 A 1818 A	2104 Decedent of H specify Cuba es 2 [X] No Usual Occupion work done of the control of the contr	ispanic Origin? (in, Mexican, Pue Specify: ation during most of w 18. Mother's Na There and Number or F Way, F e)	ame (First, Middle &a Kow Bural Route Numi allston, Date	IL. Ball Special Speci	S.A. ice Americack, White, ify: (Business/In Ctwi M. Ele me) 7, State, Zip 047 City or To	can Indian, etc. White dustry ng ctric
Never Married 2 Marned Widowed 4 Divorced 15. Decedent's E (Specify only highest gr mentary/Secondary (0-12) 12 ather's Name (First, Middle, Last Ouris Schmuck Informant's Name/Relationship 2 Annine R. Cook Method of Disposition 2 Burial 2 Cremation 3 E Donation 5 Other (Specificature of Funeral Service Lice Part 1. Enter the disease, or conshock, or heart failure. List only adiate Cause (Final isser condition	Armed Forces? 1	d- dghtr) 20b. Place cemet Oak L	a. Decedent's (Give kinds of life. Do No. Check) Do Mailing Add 1814 A 1814 A 1809 A Check 22. Nam 9705	Decedent of H specify Cuba es 2 12 No Usual Occupy of work done of T use retired Usual Occupy of work done of T use retired Usual Occupy of work done of T use retired Usual Occupy of Work done of T use retired Usual Occupy of Work done of T use retired Usual Occupy of Work done of T use retired Williams of or other place Metry of and Address	ispanic Origin? (in, Mexican, Pue Specify: ation during most of w 18. Mother's Na There and Number or F Way, F e)	ame (First, Middle &a Kow Bural Route Numi allston, Date	16b. Kind of 8 Manufa Wester Maiden Suma Palski ber, City or Towr MD 21 (20c. Location	ice - Americack, White, White, White, Gusiness/In Cturing Electric Market Elec	etc. White dustry ng ctric
Widowed 4 Divorced 15. Decedent's E (Specify only highest greentary/Secondary (0-12) 1 2 ather's Name (First, Middle, Last Ouris Schmuck Informant's Name/Relationship Cannine R. Cook Method of Disposition Method of Disposit	I Yes 2 Mily Yes, Give Yes	d- 15 dghti) 20b. Place cement Oak L	a. Decedent's (Give kinds of life. Do No. Check) Do Mailing Add 1814 A 1814 A 1809 A Check 22. Nam 9705	Usual Occupion work done of DT use retired. Usual Occupion work done of DT use retired. Usual Occupion work done of Usual Occupion work done of Or other place of Or other place of Occupion wetery and Address	Specify: ation furing most of w 18. Mother's Na There and Number or F Way, F e)	ame (First, Middle &a Kow Bural Route Numi allston, Date	Special State of the Manufa Wester. Manufa Wester. Maiden Surna Oalski ber, City or Town MD 21 (20c. Location	ity: (Business/In Cturi N Eleme) D State, Zip D 47 City or To	White dustry ng ctric
Informant's Name (First, Middle, Lass Orris Schmuck Schmuck Informant's Name/Relationship (2annine R. Cook Method of Disposition Burial 2 Cremation 3 Department of Education 2 Other (Specifications) of Funeral Service Lice Part I. Enter the disease, or conshock, or heart failure. List only addiate Cause (Final ise or condition	College (1-4or 5 St) Eler (Type. Print) Gran 2-Yarworth (Removal from State sity) ensee	d- 15 dghtr) 20b. Place comet 0ak L	Check 1814 A of Disposition only, crematory 22. Nam 9705	er rabian (Name of or other plac metery le and Address	18. Mother's Na There and Number or F Way, F 11/	ame (First, Middle & A KOU Rural Route Numi allston, Date	Manufa Wester. e, Maiden Surna Oalski ber, City or Town MD 21 20c. Location	cturi n Elei me) n, State, Zip 047 - City or To	ng ctric
annentary/Secondary (0-12) 12 ather's Name (First, Middle, Lass Dirtis Schmuck Informant's Name/Relationship 2ANNINE R. Cook Method of Disposition 2 Burial 2 Cremation 3 E Donation 5 Other (Speci- signature of Funeral Service Lice Part 1. Enter the disease, or com- shock, or heart failure. List only ediate Cause (Final lase or condition	College (1-4or 5 st) ELET (Type, Print) gran 2-Yarworth Premoval from State ify) ensee	d- 15 dghtr) 20b. Place comet 0ak L	Check 1814 A of Disposition only, crematory 22. Nam 9705	er rabian (Name of or other plac metery le and Address	18. Mother's Na There and Number or F Way, F 11/	ame (First, Middle & A KOU Rural Route Numi allston, Date	Manufa Wester. e, Maiden Surna Oalski ber, City or Town MD 21 20c. Location	cturi n Elei me) n, State, Zip 047 - City or To	ng ctric
Informant's Name/Relationship (2011) R. Cook Method of Disposition	Cler (Type, Print) gran 2-Yarworth Removal from State ify)	dghtr) 20b. Place cemet Oak [1814 A of Disposition any, crematory 22. Nam 9705	tress (Street a rabian (Name of or other plac metery le and Addres	There and Number or F Way, F 11/	SA KOU Rural Route Nurmi ALLS LON, Date 1/2006	e, Maiden Suma Oalski ber, City or Town MD 21 (20c. Location	me) n, State, Zip 047 - City or To	o Code)
Informant's Name/Relationship (2annine R. Cook Method of Disposition Burial 2 Cremation 3 [Condition 5 Other (Special Service Lice Part 1. Enter the disease, or come shock, or heart failure. List only adiate Cause (Final Isse or condition)	(Type, Print) gran 2-Yarworth Removal from State ify)	dghtr) 20b. Place cemet Oak [1814 A of Disposition ery, crematory awn Ce 22. Nam 9705	rabian (Name of or other plac metery de and Addres	There and Number or F Way, F 11/	SA KOU Rural Route Nurmi ALLS LON, Date 1/2006	ber, City or Town MD 21 (n, State, Zip 047 - City or To	
Method of Disposition Method of Disposition Method of Disposition Donation 5 Other (Specifignature of Funeral Service Lice) Part 1. Enter the disease, or complete, or heart failure. List only ediate Cause (Final ase or condition)	Permoval from State ify)	dghtr) 20b. Place cemet Oak [1814 A of Disposition ery, crematory awn Ce 22. Nam 9705	rabian (Name of or other plac metery de and Addres	Way, F	allston, Date 7/2006	MD 210 20c. Location	047 - City or To	
Method of Disposition Burial 2 Cremation 3 [Comparison 5 Other (Special Comparison 5	Removal from State	oak L	of Disposition ery, crematory AWN Cel 22. Nam 9705	(Name of or other plac METERY se and Addres	e) 11/:	Date 7 / 2006	20c. Location	- City or To	own, State
Burial 2 Cremation 3 ED Donation 5 Other (Special Information of Funeral Service Lice Part 1. Enter the disease, or compand to the companies of condition of the companies of condition of the companies of condition of the companies of condition of the companies of condition of the condition of t	ensee	Oak L	ery, crematory LAWN Cel 22. Nam 9705	or other place Metery he and Addres	11/	Date 7/2006		•	wn, State
Part1. Enter the disease, or comshock, or heart failure. List only ediate Cause (Final associated associated cause (Final associated	ensee	·	22. Nam 9705	e and Addres		7/2006	72 - 0 + 1		
Part1. Enter the disease, or comshock, or heart failure. List only ediate Cause (Final ise or condition	ulle	I the death. Do	9705	Polari			Bactumo	ore, 1	laryland
ediate Cause (Final	mplications that caused y one cause on each lin	the death. Do		becau	s of Facility S	chimunek Baltimor	Funeral	Home	2.5
ediate Cause (Final	D	10.							Approximate
ting in death)	KESI	PATRI		ALLUK					Interval Between Onset and Death
	Due to (or as	a consequence		ALLUK					
Cartellia Real Control Section	- PN	EUMO	NITA						
r, leading to immediate		a consequence							
nation is a conditions, leading to immediate a. Enter Underlying a (Disease or injury nitiated events	c								
ting in death) Last	Due to (or as	a consequence	of):						
	d								
MALE:									
Was decedent pregnant			h 3⊟Ectop	ic pregnancy					
1 □ Yes 2⊌2No		time of death					Me	onth	Day Year
, Other significant conditions (contributing to death bu	at not resulting	in the underlyii	ng cause give	in in Part I.				
						1 🗆	Yes 2□No	3 Prob	ably 4 Donknov
								Were autor	osy findings availab
							ormed?	death?	2 No
/as case referred to medical					26. Place of De	ath Check only			
□Yes 2□No	1 Impatier		utpatient 3	DOA Othe	4 Nursing	Home 5□ Res	idence 6 Oth	ner (Specify)
anner of Death ☑Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y Year) 28b.	Time of Injury	28c. Injury Work	at ?	28d. Describe	how injury occur	red	
Accident investigation			М						
☐ Homicide determined	1 28e. Place of Inju	iry - At home, f :. (Specify)	arm, street, fac	ctory, office		28f. Location (City or To	Street and Numl wn, State)	er or Rura	Route Number,
Z Medical Can	minior. On the pasts of	examination at	e, death occur novor investiga	red at the time	e, date and plac inion, death occ	e, and due to the urred at the time.	cause(s) and made	anner as sta	ated.
	and manner star	ted.							
- Tackers	MD.			0			1 .		
- Julion				KES	000		11/3/	06	
- /	completed cause of de		(Type, Print)	5601 L	och Rav	en Blud.	, Balt.	, MD	21239
ame and address of person who			B 74 .			- DUTA			
Vin 19	As decedent pregnant Inhe past 12 months? Yes 2 No Unknown Other significant conditions as case referred to medical aminer? Yes 2 No Natural 5 Pending investigatic determined Accident Natural determined Homicide Homic	Vas decedent pregnant I he past 12 months? Yes 2 No	Vas decedent pregnant the past 12 months? Yes 2 No	23c. if yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectop 1 Live birth 2 Fetal death 5 Other	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 U	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 5 Other (specify) 9 Unknown	Vas decedent pregnant 1 23c. If yes, outcome of pregnancy 1 1 1 2 1 2 2 2 2 2	Vas decedent pregnant 1 1 23c. it yes, outcome of pregnancy 1 1 23c. it yes, outcome of pregnancy 1 1 23c. it yes, outcome of pregnancy 1 1 23c. it yes, outcome of pregnancy 1 23c. it yes, outcome of pregnancy 23d. Date signed the past 12 months? 1 23c. it yes, outcome of pregnancy 23d. Date signed the past 12 months? 23c. it yes, outcome of pregnancy 23d. Date signed the past 12 months? 23c. it yes, outcome of pregnancy 23d. Date signed the past 12 months? 23c. it yes, outcome of pregnancy 23d. Date signed the past 12 months? 23c. it yes, outcome of pregnancy 23d. Date signed the past 12 months? 23c. it yes, outcome of pregnancy 23d. Date signed the past 12 months? 23c. it yes, outcome of pregnancy 23d. Date signed the past 12 months? 23d. Date signed the past 1	Vas decedent pregnant the past 12 months? Yes all No

Dosothy

			1 - For State Registrar	State	of Marylar		artment of I rtificate of		d Mental Hy	giene No. No.	06	35300	
	Physici /Medic		Decedent's Name (First, Middle, RONAL		ES ROSI				2. Date of De		., শ েত	3. Time of Death	
	Examir		4a. Facility Name (If not institution, Saint Jose	give street and no ph Medi	cal Ce	nter	4b. City, Town,	or Location of D	Death DWS OTI	4c. Coun	y of Ban	timore	
	Funeral Director		5. Social Security Number 178-32-5780	Sex MM 2□ F	7. Age (In yrs. 63	last birthday) Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of Birt Min. (Month, Da May 23,	y. 1943	9. Birthp Cour Penn	olace (State or Foreign ntry) ISylvania	
	ryland		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation				1	10d. Inside City Limits	
	h the Ma r 28a-f e	Directo	Maryland N/A 10e. Street and Number		Ba	altimor	10f. Zip Code			10g. Citizen of		1 XX Yes 2 □ No	
	leeth wit	Funeral D	318 Taplow Roa		edent Ever in U	S. 13.1	212		? (Specify Yes or No-	US 14. Ba	Ce - Americ	can Indian	
030	urs efter d at', or iten	þ	1 ☐ Never Married XX Marrie 3 ☐ Widowed 4 ☐ Divorced	d Amed F	orces? 2 ⊟ No	'	f Yes, specify Cub 1 □ Yes XXXIXIo	an, Mexican, P	Puerto Rican, etc.)		ack, White,		
212-0036	permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "netural", or Iteme 23a or 28s-f show supprintury or other traumatic event, I're Medical Examinant be muilled at ODGs.	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed		16a. Deced (Give life. I	tent's Usual Occu kind of work done DO NOT use retire	during most of d)		16b. Kind of I			
12 01	e filed wi Il Hygien other th	Be Con	17. Father's Name (First, Middle, L.			Corre	ctional		Name (First, Middle,			ernment	
ryland	hould be id Menta marked matic ev	ToB	Charles Raymond 19a. Informant's Name/Relationshi			19b Mailir	ng Address (Street	1	ry Romito	or City or Tour	State 7in	Codel	
, Ma	and 2 sealth an m 27 le		Lynne Warren Ros	e	Wife	318 1	aplow Ro	ad Balt	imore, Ma	ryland	21212		
baltimore	Pages 1 nent of H int: if ite iry or ot		20a. Method of Disposition 1 ☐ Burial A ☐ Cremation : (4 ☐ Donation 5 ☐ Other (Special Control of Control	3 □Removal from	Charles	emetery, cren	sition (Name of natory or other pla Int Crema		Date 1/9/06	20c. Location Baltimo		own, State aryland	
Dall	permit. Departn Imports eny inju		21 Signature of Funeral Service Li	Len XC	naku	22						n. Hm. Inc. ryland 2121	
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Immediate Cause (Final SEPSIS										
	/Medical Examiner		disease or condition resulting in death)	a. Due to	(or as a conseq								
	po tis	Iner	Sequentially list conditions, Lay, cash y to immediate cause. Enter Underlying Cause (Disease or injury	b. Dua to	(ur as a conseq	uands of):					-		
,007	icate be executed physician end s the burial-transit	dical Examiner	that indiated events resulting in death) Last	C	(or as a conseq		MYOPATH	IY 					
/00 XO			IF FEMALE:	d.	itcome of pregna	ancy.							
	death e atter	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	birth 2 ☐ Feta nant at time of d	Ideath 3	Ectopic pregnanc Other (specify)	у			ate of detive onth	Day Year	
rus, r	quires thet n signed b uld be deta	ρ	Part II. Other significant condition ADULT RESPIRAT	s contributing to c	death but not res	ulting in the ur	nderlying cause giv	ven in Part I.	23e. Did to	. /		ne cause of death?	
necor	The la ete hes page 2	Completed	RENAL FAILURE						24a. Was a autop perfor	an 24b. sy mad? 2 X No	Were autopprior to condeath?	psy findings available mpletion of cause of	
VII	Physicien: Th this certificete al director, pag	To Be (25. Was case referred to medical examiner?	Hospitat:	Inpatient 2	ER/Outpatien	3□ DOA O#		Death Check only or	ne)			
	After funer		27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	28a. Dare (Mor		28b. Time of Injury	28c. Injui		28d. Describe h			7	
DIVISION	To the Hospital or Attending P within 24 hours effer death. To the Funeral Director: Affer t bompletely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad 288. Place	e of Injury - At ho ling, etc. (Specif	ome, farm, stre	eet, factory, office		28f. Location (S City or Tow	treet and Num n, State)	ber or Rura	l Route Number,	
	To the Hospital or within 24 hours effe to the Funerel Dir. Completely filled in I	Medical	29a. Certifier 1/S Certifying (Check only one) 2 Medical E	caminer: On the t	e best of my kno pasis of examina oner stated.	wledge, death tion and/or inv	occurred at the tirestigation, in my o	me, date and pl opinion, death o	lace, and due to the coccurred at the time, o	ause(s) and m date and place,	anner as st	ated. the cause(s)	
	To th within To th	×	29b. Signature and title of certified	To	Mi		29c. Licens	e number 24034	2	29d. Date signe	Month, I	Day, Year)	
	121		30. Name and address of person w				Print)		had pro process and a second	11/3	106		
	Sta		TIMOTHY LOW 31. Date filed (Month, Day, Year)	32. F	7601 05 Registrar's Signa	ture Aced	RIVE TO	JWSON,	MARYLAN:	D 2120	14		
	Registr	ar	NOV 0 8 200	b Den	50 Kg6	The same of							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat 35301 06 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician /Medical 4a. Facility , or Location of Reati and number) Examiner of Death mer 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | Age (In yrs. last birthday) Months Days NONE Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. inside City Limits ral Director Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 22

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 le marked other than "natural", or items 23a or 28s-f ehow any injury or other traumatic event, Tra Medical Examinar must be notified at once. Baltimore, Maryland 21215-0036

Funeral

Director

Physician /Medical Examiner

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

by Fune	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Amed Forces? 1	13. Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto R	ify Yes or No- lican, etc.)	14. Race - American Indian, Black, White, etc. Specify:
eted t	15. Decedent's Ec	ducation 16a	a. Decedent's Usual Occupation (Give kind of work done during most of working	16b. I	Kind of Business/Industry
Completed	Elementary (0-12)	College (1-4or 5+)	life. DO NOT use regred)		INFANT
To Be	17. Father's Name (First, Middle, Last)	1 Bold	18. Mother's Name	(First, Middle, Maide	n Sumame)
	19a. Informant's Name/Relationship (7) ANONJU V. RICH	1- Mother 9	b. Mailing Address (Street and Number or Rural. 08 N. MONRCEST. B	Route Number, City	or Fewn, State, Zip Code)
	20a. Method of Disposition Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	of Disposition (Name of party, crematory or other place) (A Held (A) 12 2	9/04 Ba	ocation - City or Town, State
	21. Signature of Funeral Service Licen	500	22. Name and Address of Facility Brace 2134 Willow Soria	ley-Ash	ton Funeral HomePL
	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	olications that caused the death. Do one cause on each line.	not enter the mode of dying, such as cardiac of	respiratory arrest,	Approximate Interval Between Onset and Death
	disease or condition resulting in death)	a. Dug to for as a consequence	matrix future it	- Munh	my
xaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence c. Due to (or as a consequence			
dicalE		d.	oi).		
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	n 3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
ed by Ph	Part II. Other significant conditions co	entributing to death but not resulting i	n the underlying cause given in Part I.	,	use contribute to the cause of death?
plet				24a. Was an	24b. Were autopsy findings available
ρ				autopsy performed?	prior to completion of cause of death?
Be	25. Was case referred to medical examiner?	Hospital: N	26. Place of Death (performed? 1 ☐ Yes 2 No	prior to completion of cause of death?
To Be	examiner?	Hospital: 1 Inpatient 2 □ EF/Ot 28a. Date of Injury 28b.	utpatient 3 DOA Other: 4 Nursing Home	performed? 1 Yes 2 No Check only one 5 Residence	prior to completion of cause of death? 1 Yes 2 No 6 Other (Specify)
To Be	examiner? 1	28a. Date of Injury (Month, Day Year)	utpatient 3 DOA Other: 4 Nursing Home	performed? 1 Yes 2 No Check only one	prior to completion of cause of death? 1 Yes 2 No 6 Other (Specify)
tification: To Be	examiner? 1 Yes No 27. Manner of Death Natural 5 Pending	28a. Date of Injury (Month, Day Year)	DOA Other: 4 Nursing Home	performed? 1 Yes 2 No Check only one 5 Residence d. Describe how inju	prior to completion of cause of death? 1 Yes 2 No 6 Other (Specify) Ny occurred
tification: To Be	examiner? 1 Yes No 27. Manger of Death Natural 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier Certifying Physics	28a. Date of Injury (Month, Day Year) 28b. 28b.	DOA Other: 4 Nursing Home	performed? 1 Yes 2 No Check only one 5 Residence d. Describe how inju t. Location (Street ar City or Town, State	prior to completion of cause of death? 1 Yes 2 No 6 Other (Specify) ry occurred and Number or Rural Route Number, 3)
To Be	examiner? 1	28a. Date of Injury (Month, Day Year) 28b. Place of Injury - At home, fabuilding, etc. (Specify) /sician: To the best of my knowledge iner: On the basis of examination and	utpatient 3 DOA Cther: 4 Nursing Home Time of Injury Mork? M 1 Yes 2 No arm, street, factory, office 28:	performed? 1 Yes 2 No Check only one 5 Residence d. Describe how inju t. Location (Street ar City or Town, State d due to the cause(s at the time, date and	prior to completion of cause of death? 1 Yes 2 No 6 Other (Specify) ry occurred and Number or Rural Route Number, 9)
tification: To Be	examiner? 1	28a. Date of Injury (Month, Day Year) 28b. Place of Injury - At home, fabuilding, etc. (Specify) /sician: To the best of my knowledge iner: On the basis of examination an and manner stated.	Utpatient 3 DOA Other: 4 Nursing Home Time of Injury Mork? M 1 Yes 2 No arm, street, factory, office 28: e, death occurred at the time, date and place, and or investigation, in my opinion, death occurred 29c. License number	performed? 1 Yes 2 No Check only one 5 Residence d. Describe how inju t. Location (Street ar City or Town, State d due to the cause(s at the time, date and	prior to completion of cause of death? 1 Yes 2 No 6 Other (Specify) ry occurred and Number or Rural Route Number, 3) and manner as stated. d place, and due to the cause(s)

State Registrar NOV 0 8 2006

			1 - For State Registrar	State of	Marylar		artmen rtificat				lental Hyg	iene 0	06	353	02
	Physic	an	1. Decedent's Name (First, Middle, Las								2. Date of Dea Month	th Day	Year	3. Time of E	Death
	Physici /Medi		HAROLD E. RATCHI	FORD_							11	6	2006	0120) M
1	Examir	ner	4a. Facility Name (If not institution, give					1	Location o				nty of Death		
			5. Social Security Number 6. Se				If Under		If Under:				NA .		
	Funeral Director			M 2□F	65	last birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day	Year)	9. Birth	place (State or intry)	
			Usual Residence of Decedent	21	65						12-25	-1940		N.C.	•
	yland now		10a. State 10b. County		10c. C	ity, Town or Lo	cation							10d. Inside City	y Limits
	Mar	to	Md. NA			Bal	timor	îe						Y Yes	2 🗌 No
	3a or 28a	Il Director	10e. Street and Number 12 S. Carey Stre	et			10f. Zip	Code 2122	23		1	0g. Citizen o	of What Cou	ntry?	
980	be filed within 72 hours after death with the Maryland tal Hygiene. Id other then "neturel", or itema 23a or 28a-1 ehow event, the Madical Examinant mat be multified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decede Armed Forc 1 Tyes 2 If Yes, Give Year or Date	es? ₹No		Was Deced If Yes, spec	offy Cuba	n, Mexican	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)	В	lace - Americal Americal Americal American Black, White Cify: Black	etc.	
2-0	72 h	Completed	15. Decedent's Ed (Specify only highest grades)	ucation de <i>completed)</i>		16a. Dece	kind of wo	rk done c	lurina most	t of worki	ng	16b. Kind of	Business/Ir	ndustry	
12	hen hen	mp	Elementary/Secondary (0-12)	College (1-4	or 5+)		DO NOT us)			377			
22	Hygie Hygie Ither t		7th grade 17. Father's Name (First, Middle, Last)			Dis	sable	<u> </u>	19 Motho	rie Name	(First, Middle,	NA	1		
Maryland 21215-0036	permit. Pages 1 and 2 should be 1 Department of Health and Mental I Important: if item 27 te marked or eny fnjury or other treumatic eve once.	To Be	Jack	Alexa	nder		chford		Fai	nnie		St	tevens		
Mar	12 sh h and 7 le m treum		19a. Informant's Name/Relationship (7 Vera Ratchford		fe	19b. Mailir	ng Address Care	(Street a	and Numbe	r or Rura	ltimore,	, City or Tow Md .	m, State, Zij 21223		
	1 and Healt tem 2	3	20a. Method of Disposition	***						-		20c. Location			
Baltimore,	ages int of t: if it		1 ☐ Burial 2 ☐ Cremation 3 ☐		ate	Place of Dispo cemetery, crer	natory or o	ther place	1			LOO. LOOMIO	ii Oity oi i	own, otato	
ቜ	artme ortan Injur		4 ☐Donation 5 ☐ Other (Specify 21. Signature of Funeral Service License		Lo	udon Pa	ark C		1 as of Facility	1-10		altim		1d	_
Ba	Depa Impo eny to		& Lades	Wo	me	-				•	March F. , Baltin	H. Ea	st Ma	21202	
8760,4	death certificate be executed Reading physicien and a for use as the burial-transit	dical Examiner	shock, or heart failure. List only of firmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or b. Use to (cr		SP PAquence of): TTPLE [Quence of):	steyn STR	OKE	A					Interval Betwo	
P.O. Box 6	the death certific by the attending pached for use as	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outco 1 □ Live birth 4 □ Pregnan 9 □ Unknow	n 2 ∐ Feta tattime of c	af déath 3□	Ectopic pro					1	Date of delivership	ery Day Ye	3 a .r
Division of Vital Records, P	The law requires that the death ste hes been signed by the atte page 2 should be detached for	d by Pi	Part II. Other significant conditions co	ontributing to deat	h but not res	sulting in the ur	nderlying ca	ause give	n in Part I.					ne cause of dea	
900 000	law re as bee 2 sho	plet	HYPERTENSION								24a. Was a	24b	. Were auto	psy findings av	/ailable
č	The ste he page	E	HEPATITIS C								autops perform 1 Yes 2	led?	death?	mpletion of cau 2□ No	1SO OF
ita	ian: ntifica	Bec	25. Was case referred to medical						26. Place	of Death	(Check only on		103	20140	
<u>~</u>	hysic lis ce	2	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Minp	atient 2 🗆	ER/Outpatien	t 3 00	A Othe	r: 4 🗆 Nur	rsing Hon	ne 5∐Reside	nce 6 🗆 O	ther (Specif	(y)	
0	ng PI fter th		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of I	njury Day Year)	28b. Time of fnjury	2	8c. Injury Work	at ?	2	8d. Describe ho	w injury occu	urred		-
<u>0</u>	Attending Physician: r death. ector: After this certifice by the funeral director;	atle	2 Accident investigation		,	,,	М		es 2□N	40					
<u>X</u>	l or Att efter d Direct	Certification;	3 Suicide 6 Could not be 4 Homicide determined	286. Place of	Injury - At h etc. (Specia	ome, farm, stre fy)	eet, factory	, office		2	8f. Location (Sti City or Town	eet and Num State)	ber or Rura	I Route Numbe	ЭГ,
	To the Hospital or Attending Physician: The lav within 24 burus effect death. To the Funeral Director: Affer this certificate hes completely filled in by the funeral director, page 2	edical C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	rsician: To the be iner: On the basi and manner	s of examina	owledge, death	occurred a	at the tim in my op	e, date and inion, deat	d place, a h occurre	and due to the ca	use(s) and nate and place	nanner as s and due to	tated. the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c	. License	number		29	d. Date sign	red (Month,	Day, Year)	
	- s - ō		Idan Chrare	/ 4	nD					CE:	7411	,			
•	Λ		30. Name and address of person who c			n 23a\ /Tuna		441.	1673	56/	/7//	1116/	2000	0	
	' b							Bal	Timon	E 1	40 2.	211			
	Sta	te	31. Date filed (Month, Day, Year)	32. G eg	istrar's Signa	aturo A	and P	77111	, -010/2	- 1	- 21	201			
	Registr		NOV 0 8 20	06	RUSI I	A. S. S. S. S. S. S. S. S. S. S. S. S. S.									

			For State	State of Ma					ntal Hygie	2006	35303
			State Registrar Decedent's Name (First, Middle, Las	st1		Cenificat	e of Deat		Reg. Date of Death	No.	3. Time of Death
	Physici		Francis)	Cavier	RU	vKa	111			Day Year V 5 06	11-5
	/Medic Examin		4a. Facility Name (If not institution, give		100	4b. City.	Town, or Locatio		Olempe	4c. County of Death	
ı	LXamii	CI	Baltimore 1	VA Medic	cal len		Itimo			N	A
	Funeral		Social Security Number 6. S	ex 7. Ag	e (In yrs. last birt	Months	1 Year If Und Days Hours	ler 24 Hrs. 8	Date of Birth (Month, Day, Ye	ar) 9. Birth	nplace (State or Foreign untry)
	Director		220-36-1509 Usual Residence of Decedent	LW 20 F	64	Yrs.		1	ary 15,		ryland
	land ow		10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Limits
	Mary	tor	Maryland Baltimo	***	Owings	Mills					1 ☐ Yes 2☐ No
	th the or 28g	Funeral Directo	10e. Street and Number	JI e		10f. Zip	Code	-	10g.	Citizen of What Co	ıntry?
	23a c	al	3219 Caves Road				21117		Unit	ed States	of America
	ar deg	nue	11. Marital Status	12. Was Decedent 1 Armed Forces?		13. Was Dece	dent of Hispanic (cify Cuban, Mexic	Origin? (Specif can, Puerto Ric	y Yes or No- can, etc.)	14. Race - Amer Black, White	ican Indian,
36	within 72 hours after death with the Maryland one. than "natural", or items 23e or 28e-f show the Madical Exeminer must be notified at	by F	1 ☐ Never Married 2 🙀 Married 3 ☐ Widowed 4 ☐ Divorced	1 Tyyes 2 ☐ N If Yes, Give Year or Dates:	1959–62	1 ☐ Yes	2No Speci	ify:		Specify: Cau	ıcasian
21215-0036	2 hou atura		15. Decedent's Ed	ducation		Decedent's Usu	al Occupation		16b	. Kind of Business/l	
2	hin 7. B. Madi	Completed	(Specify only highest gra	de completed) College (1-4or 5	+)	life. DO NOT u				Commeric	
	ed wit	Соп		4	Sel	f Emplo	yed Inte			Servi	.ce
<u>n</u>	ba filk Ital Hy d oth	Be	17. Father's Name (First, Middle, Last)				18. Mo	ther's Name (F	First, Middle, Maid	den Surnarne)	
Maryland	nould I Men narke	은	Francis Xavier		4.01				roblewsk		
<u>a</u>	d 2 sh th and 7 is n traun	2 8	19a. Informant's Name/Relationship (7) Mrs Wendy L. Rurk	** *						ly or Town, State, Z.	
	1 an Heal tam 2	1 3	20a. Method of Disposition	ca (Spi	20b. Place of	Disposition (Nat	ne of	Date	9 20c.	Mary Land Location - City or 1	Z111/ Town, State 21117
JO L	bages ent of nt: If i		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify			y, crematory`or c		11/1			, Maryland
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at once.		21. Signature of Funeral Service Licen		Garriso		t Vet.Ce	- W •			Directors,I
m	Department Department Important in Suny in Sun	E 1	Handa L	Lemme	J	8728 L	iberty R	Road, R	andallst	own. Mary	land 21133
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused one cause on each lir	the death. Do r						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	· 5000	raneon	us bo	acteria	1	ritoni -	Lic	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of		ACT COL	· PC.		'''	
	Lxummer	er	Sequentially list conditions,	b. Hundridge ex-	à consequence (46					
36	ted	nlne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence (nj.					
/	execunate and al-tra	Examin	that initiated events resulting in death) Last	C. Due to (or as	a consequence o	of);					
8760,	ficate be executed g physician and is the burial-transit	dlcall		d							
9	rtifica ng ph as th	Medi	IS SCHALE.								
Вох	th cer tendir r use	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1□Live birth	of pregnancy 2 Fetal death	3 □Ectopic p	egnancy			23d. Date of deliv	*
о. П	The law requires that the death certificate has been signed by the attending proage 2 should be detached for use as	Physician/Me	1 Yes 2 No	4☐ Pregnant at 9☐ Unknown	time of death	5 Other (sp	pecify)			Month	Day Year
<u>α</u>	that that the ad by detact	Phy	Part II. Other significant conditions of	ontributing to death b	ut not resulting in	the underlying o	ause given in Par	rt I	23e. Did tobacc	o use contribute to	the cause of death?
Records,	signs d be	d by	Back Pain			the anabitying a	aaso giron iir t ai				bably 4 □Unknown
COL	w requir been si should	Completed							24a. Was an	24h Were aut	opsy findings available
Re	The lav	дшс							autopsy performed	prior to co	ompletion of cause of
ta		Be C	25. Was case referred to medical				26. Pla	ace of Death (C	1 ☐ Yes 2 ☑ Check only one)	No 1 ☐ Yes	2 No
<u> </u>	ysician: is certific director,	To B	examiner? 1 \(\text{Yes} \) 2 \(\text{No} \)	Hospital: 1 Inpatie	nt 2 ER/Out	patient 3 DC	Othor			6 ☐Other (Speci	ify)
0	Attending Physician: r death. actor: After this certific by the funeral director.		27. Manner of Death 1 ☐ Matural 5 ☐ Pending	28a. Date of Injur (Month, Day		ime of 2	8c. Injury at Work?	280	d. Describe how in	jury occurred	
Sio	tendi leath. tor: A the fu	catle	2 Accident investigation 3 Suicide 6 Could not be			М	1 ☐ Yes 2				
Division of Vital	i or Atteno after death Diractor: I in by the	Certification;	4 Homicide determined	28e. Place of Inju- building, etc	ury - At home, fai c. (Specify)	m, street, factory	r, office	28f	Location (Street City or Town, St	and Number or Rur ate)	al Route Number,
_	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Ph	ysicien: To the best of	of my knowledge	death occurred	at the time, data	and place, and	I due to the cauco	(s) and manage as	stated
	e Hos 24 h a Fur letely	edical	(Check only 2 Medical Exam	niner: On the basis of and manner sta	examination and	for investigation	, in my opinion, d	eath occurred	at the time, date a	and place, and due t	to the cause(s)
	within To th	Me	29b. Signature and title of certifier		-	290	. License numbe	er	29d. I	Date signed (Month,	Dey, Year)
1			I Clarel 14	Janadee	HD	16	0646		Non	member 5	2006
			30. Name and address of person who		eath (Item 23a) (Type, Print)		_			
	Ψ			ic deeplo	10	N. Grec	ne St.	Baltin	more, t	10 212	01
	Sta Registr	- 4	31. Date filed (Month, Day, Year) NOV 0 8 20	32. Registra	ar's Signature	auta k					
	negisti	и і	1101 0 8 20	JUD BROWN	es sign	Locals)	7				

DHMH 17 Rev 1/2001

ORIGINAL

			For State	State of Ma	aryland	-	artment of F rtificate of		and Me	_	_	0000	05001	
ı.	横		Registrar 1. Decedent's Name (First, Middle, La	ist)	_		tilicate of	Dealli	2	2. Date of De			3 5 3 0 L 3. Time of Death	Ł
	Physici /Medic		Marjori	e W. Rocl	kett				N	ovembe	er]	2008	5 2:00 AM	4
	Examin		4a. Facility Name (If not institution, gi				4b. City, Town, o		of Death			c. County of De		
	Funeral	•	Arcola Health an 5. Social Security Number 6.			ast birthday)	Wheato		24 Hrs. 8	3. Date of Bir	+h	Iontgome	irthplace (State or Foreig	ın
Ċ	Director			1□M 2 ½ F	81	Yrs.	Months Days	Hours	Min.	June 20	$1, \stackrel{\text{Yea}}{1}$	925 No	rth Dakota	
	and w		Usual Residence of Decedent 10a, State 10b, County		10c. City,	Town or Lo	cation						10d. Inside City Limits	 s
	Maryll-f sho	to	Maryland Montgom	erv		Sil.	ver Sprin	าด					1 □Yes 2 No	
	th the	Director	10e. Street and Number	CLY			10f. Zip Code	······································			10g. C	Citizen of What (Country?	
	ath wii	ral	2808 Hathaway Te					0906				nited St		
_	ter de items iner ir	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent 8 Armed Forces? 1 ☐ Yes 2 🔀 N		3. 13.	Was Decedent of H If Yes, specify Cub	lispanic Original de la communicación de la co	gin? (Speci n, Puerto Ri	ify Yes or No ican, etc.))-	14. Race - An Black, Wh		
036	ours af	þ	3 X Widowed 4 Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 🖾 No	Specify:				Specify:	White	
2-0	72 hc "natul dical	etec	15. Decedent's E (Specify only highest gr		1	16a. Deced (Give	dent's Usual Occup kind of work done DO NOT use retired	oation during most	t of working	,	16b.	Kind of Busines	s/Industry	
121	within iene. than the Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)		Jonoruse retiret Homemaker					Own H	Iome	
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. • marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle, Las					18. Mothe				en Surname)		
ylaı	ould b Menta arked	To	Eugene M. Walla							mraski				
Mar	d 2 sho		19a. Informant's Name/Relationship				ng Address (Street					•	, ,	
	s 1 and 2 f Health item 27 i	-	John D. Rockett, 20a. Method of Disposition	Son	20b. Pla	ace of Dispo	sition (Name of	- 1	Da	te		Lng, Mar Location - City o	ryland 20906 or Town, State	
E	Pages nent of I int: If its		1 X Buria! 2 □ Cremation 3 [4 □ Donation 5 □ Other (<i>Speci</i>		Gati	e of f netery	natory or other plac leaven	INC	ovembe 2006	er 6,	Sil	ver Spri	ng, Maryland	f
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lice	nsee		1 22	Name and Addre	ess of Facilit Pumph	v	uneral	L Hc	me/Rock	ville, Inc.	
	<u> </u>		23a. Part1. Enter the disease, or con	nnlications that caused	MOO19	98 30	00 West Mo	nteom	erv At	re. Ro	cky		D 20850-280! Approximate	
	Physician		shock, or heart failure. List only Immediate Cause (Final	one cause on each lin	ie.					. repliatory a			Interval Between Onset and Death	
	/Medical		disease or condition resulting in death)	a. Pneumor Due to (or as		ence of):								_
	Examiner	L.	Sequentially list conditions,	b. End Sta	ige Li	ung Di	sease							
	par /	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	South to for say.	a montheigh	ande our								
oʻ	an and rial-tra		resulting in death) Last	Due to (or as	a conseque	ence of):								_
68760,	ate be	edical		_d	·									
_	The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial-transitions.	/Me	IF FEMALE:	23c. If yes, outcome	pf pregnan	ісу						23d. Date of d	olivony	
. Box	death e atter	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 4□Pregnant at	2 🗌 Fetal	death 3	Ectopic pregnancy Other <i>(specify)</i>	у			Ì	Month	Day Year	
д О	at the de i by the stached	Phys	9 Unknown	9∐Unknown							.			
ds,	iires thai signed t d be det	by	Part II. Other significant conditions Coronary Arter		it not resul	ting in the ui	nderlying cause giv	en in Part I.					to the cause of death? Probably 4 ₩Unknowr	n
Vital Records,	w require been signature	Completed	Diabetes, Hyper	tension					- 0	24a. Was		1	autopsy findings available	_
Re	Physician: The lar r this certificate has ral director, page 2	omp	Deep Vein Thro		nt Le	 γ				autor perfo		prior to death?	completion of cause of	
/Ital		BeC	25. Was case referred to medical examiner?			>			of Death (Check only o		1010	3 2 1 1 1 1	_
0	Physic this c	မ	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 Inpatie		R/Outpatien		4 X Nu				6 □Other (Spury occurred	ecify)	_
on	fte ne	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day		Injury	Wor	k? Yes 2∐1		d. Describe i	now inj	ury occurred		
Division or	r Atter er dea irector	Certification:	3 Suicide 6 Could not be determined				eet, factory, office		28	f. Location (8 City or Tox	Street a	and Number or I	Rural Route Number,	
ā	pital o urs aft eral Di		One Continue (M) Continue D						<u> </u>					_
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	Medical	29a. Certifier 1	nysician: To the best ominer: On the basis of and manner sta	examination	on and/or in	vestigation, in my o	me, date an opinion, dea	id place, an ith occurred	d due to the dat the dat the time,	date a	s) and manner and di	as stated. ue to the cause(s)	
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Me	296. Signature and title of certifier	(A)	200		29c. Licens	e number			29d. D	ate signed (Mor	nth, Day, Year)	
	<u>_</u>		Mare	رس		0	D34	472			Nov	vember 3	, 2006	
	33		30. Name and oddress of person who Lynne Diggs, M.D			23a) (Type, ticut	Print) Ave. #20	6. Ke	nsino	ton. M	1arv	land 2	0895	
N.	Sta	te	31. Date filed (Month, Day, Year)	32. gistra				,		,				_
	Registr	ar	NOV 0 8 2	UU6 Block	e d	1. Asp								

State of Maryland / Department of Health and Mental Hygiene

			For	State of	of Marylar		artment of H		Mental Hy	giene				
			State Registrar			Ce	rtificate of	Death		Reg. No	6 3530	5_		
-	Physicia	nn.	Decedent's Name (First, Middle	, Last)					2. Date of Dea Month		3. Time of Deat			
7	/Medic	al .			ent Ric	ucci				er 6, 20		М		
	Examin	er	4a. Facility Name (If not institution	, give street and nu	mber)		4b. City, Town, o	r Location of Death		4c. County of	Death			
		4.	Summerville	Home of	Potomac 7. Age (In yrs		If Under 1 Year	Potomac If Under 24 Hrs.	8. Date of Birt	<u>, </u>	Montgomery	roiem		
	Funeral		5. Social Security Number	1 X M 2 ☐ F		V	Months Days	Hours Min.	(Month, Day		Birthplace (State or Fore Country)			
ь	Director	-	577-09-4816 Usual Residence of Decedent		88	5			June 19	9, 1918 W	ashington,D.	.C.		
	land ow at	Ì	10a. State 10b. County		10c. C	ity, Town or Lo	ocation				10d. Inside City Lin	nits		
	Many -f sh fied	ţ	Maryland Mon	ntgomery			C41	lver Spri	no		1 □ Yes 2 🔀]No		
	r 28e	Director	10e. Street and Number	regomery			10f. Zip Code	LVCI UPII	ng	10g. Citizen of Wh	nat Country?			
	h wit 23a o st be		15311 Pine	Orchard	Drive #	[‡] 26		20906		Uni	ited States			
	be filed within 72 hours after death with the Marylan Hygione. d other tian "natural", or items 23a or 28a-f show either tine Medical Examiner must be notified at	Funeral	11. Marital Status		edent Ever in U		Was Decedent of H If Yes, specify Cuba		pecify Yes or No Rican, etc.)	14. Race -	- American Indian, White, etc.			
ဖွ	after or ite		1 ☐ Never Married 2X Marri	ed 1X1Yes	2 □ No		1 ☐ Yes 2 🗓 No	Specify:	, ,	Specify:	Time, etc.			
21215-0036	ours ural"; I Exa	d by	3 ☐ Widowed 4 ☐ Divorced	Year or I	Dates: WWI	I					White			
ب م	72 h "natu dica	Completed	15. Decedent (Specify only highes	's Education st grade completed,	1	i (Give	dent's Usual Occup kind of work done DO NOT use retired	during most of work	king	16b. Kind of Busi	ness/Industry			
7	vithin ane. than	d I	Elementary/Secondary (0-12)	1 .	(1-4or 5+)	ine.		,		~ C				
N T	Hygie ther nt, th		17. Father's Name (First, Middle,	Last)			Buaget	Officer 18. Mother's Nam		Delense Maiden Surname,	Mapping Age	ncy		
ano	antal ed o	Be	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Louis Ri	ovooi					ina Petro	•			
Maryland	should be filed within 72 hours after death with the Maryland and Mertal Hyglene. s marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	2	19a. Informant's Name/Relations		cucci	19b. Maili	ng Address (Street	and Number or Ru						
¥a	d 2 Ith a 27 is trat		Brenda K. Kel	hr/ Daugh	tor	12500	Colit Co	onle Count	- Nonth	Dotomoo	Manual and 200	070		
ē,	Heal Heal tem 2		20a. Method of Disposition		20b.	Place of Dispo	osition (Name of	i	Date	20c. Location - C	Maryland 208 City or Town, State	0/0		
ō	Pages nent of I ant: If ite ury or o		1 X Burial 2 □ Cremation 4 □ Donation 5 □ Other (S		State	•	matory or other place	Nov	ember 2006	D = =141	1 - 1/21	1		
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Evneral Service		Pa:	rklawn 2	Memorial 3 2. Name and Addre	ss of Facility Ro	bert A.	Pumphrev	le, Maryland Funeral Hor	a me/		
Ba	Dep Imp any			7/2	4 M003	135	Rockvill	e, Inc. e, Maryl	300 West	Montgom	Funeral Hor nery Avenue			
			23a. Part1. Enter the disease or shock, or heart failure. List	complications that	caused the dea	ith. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory a	rrest,	Approximate			
	Physician	0	Immediate Cause (Final						Interval Between Onset and Death	ה ח				
	/Medical		disease or condition resulting in death)		or as a conse		Cardiovas	cular Dis	sease					
Ü	Examiner				(4. 4. 4. 4. 4. 4. 4. 4. 4. 4. 4. 4. 4. 4	1				ease				
	ACTUAL	je l	Sequentially list conditions,	Due to	or as a conse	uence of:								
	cuted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C.										
ó	an ar rial-tı	ŭ	resulting in death) Last	Due to	(or as a conse	quence of):								
68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial-transit	edical		d										
	ntifica ng ph as th	Med	IF FEMALE:									-		
Вох	th ce tendi	Physician/M	23b. Was decedent pregnant in the past 12 months?		utcome pf pregu birth 2 □ Fe		□Ectopic pregnanc	у		23d. Date Mont	and the second second	- 3		
Ш	e dea he at ied fo	sici	1 Yes 2 □ No	4□Preg 9□Unk	nant at time of	death 5[Other (specify)	•		WOTE	n Day real			
P.O.	at the	F	9 ☐ Unknown Part II. Other significant condition		death but eat vo	aulting in the u	undoduina aquan air	on in Dort I	220 Did to	abaasa uga santrih	oute to the cause of death	2		
Ś	res that the de signed by the a be detached f	þ						ren in Fan I.	1 🗆 `		B Probably 4 ☐Unkno			
orc	w requir been si should b	ted	нурегтеп	sion, Co	ronary .	Artery	Disease			165 2 <u>A</u> 1110 3	TODADIY 4 OTKIK	OWII		
e C	elaw hasbe	ple	Generaliz	ed Vascu	lar Dis	ease, I	Dementia		24a. Was autor	osy pri	ere autopsy findings availa ior to completion of cause	able of		
or Vital Records,	ding Physician: The n. After this certificate he funeral director, page	Completed	Comfort a	nd Hospi	ce Care				1□ Yes		eath? □Yes 2□No			
Vita	ician: Th certificate ector, pag	Be	25. Was case referred to medical examiner?	Lipopital			Lou	26. Place of Dea			Assist	ed		
70	hysi this c	P	1 ☐ Yes 2 No		Inpatient 2			4 🗆 Nursing n		dence 6 XOther	(Specify) Living	Cu		
E C	ing F	on:	27. Manner of Death 1 Natural 5 Pendin	g (Mo	e of Injury nth, Day Year)	28b. Time o Injury	Wo		28a. Describe i	how injury occurred	3			
Sic	tend feath tor: /	cati	2 Accident investig 3 Suicide 6 Could i	not bo	o of injury. At l	hama farm at	M 1 □	Yes 2 □ No	28f Location (Stroat and Number	r or Rural Route Number,			
Division	or At or at Direct in by	Certification:	4 Homicide determ	inod 200. Flat	ding, etc. (Spec		reet, factory, office		City or Tox		or nural noute Number,			
_	pital		29a. Certifier 1 X Certifyin	ng Physician: To th	e hest of my kr	nowledge dea	th occurred at the ti	me, date and place	and due to the	cause(s) and man	ner as stated	- 2		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely illied in by the funeral director,	Medical		Examiner: On the							nd due to the cause(s)			
	o the	Me	29b. Signature and title of certifie	r 4. 0	_	1	29c. Licens	se number		29d. Date signed	(Month, Day, Year)			
	->-0		> 1. JM	1000 d	we	in	′	D53367		Norramh	or 7 2006			
	/x/		30. Name and address of person	who completed car	use of death (Ite	em 23a) (Type	Print)	וסכככת		Novemb	er 7, 2006			
	11.		Shyamsudar Ra	•				117 51174	er Sprin	o. Marv1	and 20902			
	Sta	te	31. Date filed (Month, Day, Year)	32.	Registrar's Sign	nature	THE THE PARTY OF	LI DILY	President	9 144 J L				
	Regist		NOV 0	8 2006	Magica .	H.	Brester							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU 6 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 19:31 PM James Edward Russell NOV 2006 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death HOSPITAL BALTIMORE N/A AGNES 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 1 X M 2 ☐ F 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 5. Social Security Number Days 044-30-6890 67 1939 1, Connecticut Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore Catonsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 302 Cedar Run Place, Apt. M 21228 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White Specify: 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 Sales Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Edward Russell Helen Hooper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James E. Russell - Son 10114 Franklin Street, Omaha, NE 68114 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition West Arundel 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State A Donation 5 ☐ Other (Specify) 11-8-2006 Odenton, MD Crematory
Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 Approximate Interval Between Onset and Death Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ISCHEMIC BOWEL DISEASE DAYS disease or condition resulting in death) Due to (or as a consequence of): NECROTIZING PANCREATITIS DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Due to (or as a consequence of):

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

items 23a or 28a-f ehow

"natural",

permit. Pages 1 and 2 should be file Department of Health and Mental Hy, importent: If item 27 is marked othe eny injury or other traumatic event, gates.

Director

Funerai

þ

Completed

filed within 72 hours after death with the Maryland Hygiene.

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed

Records, P.O. Box 68760,

Division of Vital

Completed by Certification: To

dical Exan	that initiated events resulting in death) Last
cianymedical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No

9 Unknown

23c. If yes, outcome of pregnand	
1 ☐ Live birth 2 ☐ Fetal of	0
4☐Pregnant at time of dea	th
Q[] Hokoowa	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

h	3 Ectopic pregnand 5 Other (specify)

23d. Date of	delivery
Month	D

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📆 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

		 	24a. Was an autopsy performed?
			1 Yes 2,∕2No
25. Was case referred to medical		26. Place of Death	Check only one
examiner?	4.4		

				1 ☐ Yes 2 🔼	No 1 ☐ Yes 2	No			
		26. Place of Death Check only one							
atient	2 ER/Outpatient	3□ DOA Othe	or: 4 ☐ Nursing Hom	ne 5 🗆 Residence	6 ☐Other (Specify)				
njury	28b. Time of	28c. Injury	at 2	8d. Describe how in	jury occurred				

	examiner? 1 ☐ Yes 2 💢 N	lo .	Hospital:	2 □ E	ER/Outpatient	3 🗆 [OOA Other: 4	☐ Nursing H	lome 5 Residence	6 ☐Other (Specify)
27	Manner of Death Natural Accident	5 Pending investigation		Year)	28b. Time of Injury	М	28c. Injury at Work?	2 🗆 No	28d. Describe how inj	
	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	e 28e. Place of Injur building, etc.	y - At hou (Specify	me, farm, street	t, facto	ory, office		28f. Location (Street a City or Town, Sta	and Number or Rural Route Number

29a. Certifier	1 (X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
(Check only	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
one)	and manner stated.

29b. Signature and title of certifier Fyothi Runam,	MD
--	----

29c. License number P19925 29d. Date signed (Month, Day, Year) NOV, 04,2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900 S. CATON AVENUE, BALTIMORE, MD-21229 JYOTH PUNNAM

31. Date filed (Month, Day, Year) NOV 0 8 2006



DHMH 17 Rev 1/2001

Registrar

after ceath

within 24 hours a

Medicai

To the Hospital or Attending Physician: The law requires that the death certificate be executed

After

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

within 24 hours a

To the Funeral

attending physician and for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death Month 1. Decedent's Name (First, Middle, Last) Judith Martin Roden 4b. City, Town, or Location of Death 4a. Facility Name ([f not institution, give street and number) 4c. County of Death TIMORE If Under 24 Hrs. MORE Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number Days Months 1 ☐ M 2 🕱 F Mar 9, 309-44-4151 1943 Wisconsin 63 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 21 No Director MD Baltimore Reisterstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 107 Rockrimmon Road 21136 Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify Specify: þ White 3 ☐ Widowed 4 IX Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) yrs Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emma Smith ပ္ John Martin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1541 N. Laurel Avenue Apt. 106 Los Angelos, CA John Roden Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □xBurial 2 □ Cremation 3 □ Removal from State Pikesuille MD Druid Ridge Cem. 11/6/06 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 11824 Reisterstown Road 21. Signature of Funeral Service Licensee Eline Funeral Home Reisterstown, MD 21136 allen U 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) e to (or s a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No 24a. Was an 1□ Yes 20 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 1 Yes 2 ER/Outpatient 3 DOA 1 Inpatient ို 28a. Date of Injury 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 Pending investigation 2 No 1 Yes 2 Accident 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2401 W Belvedere Avenue 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21215-5271 Baltimore, MD Christian Minshall

State Registrar 31. Date filed (Month, Day, Year)



	1 - For State Registrar	State of	Maryland /		tment of H		nd Mental Hy	/giene	006	35308
Physician /Medical	Decedent's Name (First, Middle, Melvin Robinson	Last)					2. Date of D Month 10		Year 2006	3. Time of Death 1:30 P M
Examiner	4a. Facility Name (If not institution, Forest Haven Nursin	ng Home			b. City, Town, or B	altimore	City		ounty of Death	
Funeral Director	5. Social Security Number 216–24–7532 Usual Residence of Decedent	S. Sex	7. Age (In yrs. last b		If Under 1 Year Months Days	If Under 24 Hours	Min. 8. Dale of B (Month, D 10/08	irth Pay, Year) /1930	9. Birthi Coul	place (State or Foreign htry) MD
death with the Maryland ms 23e or 28er! ehow I mast ce notified at	10a. Stale 10b. County MD		10c. City, To	wn or Loca		more Cit	y		1	10d. Inside City Limits 1 Yes 2 No
ath with the Mar 23s or 28s-1 e	10e. Street and Number unknown	_			10f. Zip Code Ut	nknown		10g. Citizer	of What Cour USA	•
gas 1 and 2 should be filed within 72 hours after death with the Marylan gas 1 and 2 should be filed within 72 hours after death with the Marylan it of Heelih and Mental Hygiens and Heelih Hygiens or items 73 a narked other then "netural", or items 23 a or 28a-1 show or other treumatic event, the Madical Examinar mant be notified at To Be Completed by Funeral Director	11. Marital Status 1 X Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed For	2 (X No		s Decedent of Hi es, specify Cuba Yes 21 No	spanic Origin n, Mexican, P Specify:	? (Specify Yes or N ruerto Rican, etc.)	1	Race - Americ Black, White, pecify: black	etc.
If it is the control of the control	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12th			(Give kırı	it's Usual Occupa ad of work done of NOT use retired	luring most of)	working		of Business/In-	dustry
should be filed and Mental Hyging Mental Hyging I marked other umatic event, I To Be Co	17. Father's Name (First, Middle, Launknown	ast)					Name (First, Middle unknown	, Maiden Su		,wii
t and 2 sho Heelth and m27 is m ther treum	19a. Informant's Name/Relationshi Wanda Tilahun / Dau 20a. Method of Disposition			6			Baltimore, 1	MD 2122	29	
2 5 5 5	14 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	city)	tate cemete	ery, cremat ison Fo	or (Name or ory or other place orest Ceme lame and Addres	etery 1		Owings	Mills, M	
permit. Departition imports eny injury	23a. Part 1. Enter the disease, or co	_ gone	used the death. Do	638	N. Gilmor	Street	Wylie Fund ; Baltimore,	Maryla		7 Approximate
Physician Medical Examiner print Physician and Physician and Physician Examiner al Examiner	Inmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (o	r as a consequence	Of):			er Met		5es	Interval Between Onset and Death
The law requires that the death certificate be executed the has been signed by the attending physicien and sage 2 should be detached for use as the buriat-transit completed by Physiclan/Medical Examir	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live bir	ome of pregnancy th 2 □ Feta! death nt at time of death vn		topic pregnancy ther (specify)			23d.	Date of delive Month	ry Day Year
w requires that been signed the should be det	Part II Other significant conditions	s contributing to dea	ith but not resulting	in the unde	rlying cause give	n in Part I,		obacco use o		e cause of death?
	25. Was case referred to medical					00 Blass 44	1□ Yes	ormed?	prior to con death?	osy findings available inpletion of cause of
hyeici this cer al direc	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 🔲 Inp	patient 2 ER/O	utpatient :	Otho		Death <i>Check only o</i> g Home 5 ☐ Resi		Other (Specify)
fiter mer	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not	he					28d. Describe	how injury oc	curred	
To the Hospital or Attendia within 24 hours effer deeth. To the Funeral Director: A completely filled in by the tumedical Certification of the formal medical Certification.	4 Homicide determine	ed 286. Place o	f Injury - At home, fa				City or Tol	wn, State)		Route Number,
To the Hosp within 24 hou To the Fune completely fi	(Check only one) 2 Medical Ex	Physician: To the basaminer: On the basand manne	is of examination ar	e, death oc nd/or invest	igation, in my opi	nion, death o	ccurred at the time,	date and plac	manner as sta ce, and due to gned (Month, L	the cause(s)
7	Name and address of perspn wh	Val	Of death (Item 232)	(Type Prin	D28	595		11/3/	16	ray, (Gal)
State	195 neem La 31. Date filed (Month, Day, Year)	Khani 32. Re	7220 - trar's Signature	-Parl	LHeigh	ts Ave	nac, B	4/to.	mo	21208
Registrar OHMH 17 Rev 1/2001	NOA 0 8	2006	ene St	As	all s					

DHMH 17 Rev 1/2001

			For State Registrar	State of Marylar		rtment of Health			ene 006	35309
	Physicia /Medic Examin	al .	1. Decedent's Name (First, Middle, Last A A A A A A 4a. Facility Name (If not institution, give	Re	dd	4b. City, Town, or Location	/	Date of Death Month	Day Year Year 4c. County of De	6 70,33 PM
	Funeral Director	Ĭ	Catons ville (5. Social Security Number 6. Se	common 5 x 7. Age (In yrs.	last birthday) 42 Yrs.	Catons	der 24 Hrs. 8.	Date of Birth Month, Day, Une 4,	9. 8	timore inthplace (State or Foreign Dounty) lary land
	e Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Marylank N/		ty, Town or Loc					10d. Inside City Limits 1 XYes 2 ☐ No
	th with th	Funeral Director	302 North Chape	I Gate Lane,	Apt. G	10f. Zip Code 2 122	.9	10	g. Citizen of What C United	
2-0030	n 72 hours after death with the Maryland "naturel", or liems 23e or 28a-f show sulcal Evanirer must be notified at	by	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Vas Decedent of Hispanic Yes, specify Cuban, Mexi ☐ Yes 2 (Se No Special Sp		y Yes or No- can, etc.)	14. Race - Am Black, Wh Specify:	
717	filed within 72 h Hygiene. ther then "natu ant, II a Medic	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	16a. Deced (Give life. D	•		ŀ	tarber C	,
yland	outd be fill Mental Hy larked oth	To Be	17. Father's Name (First, Middle, Last) Silas Redd			F	Bernic	e Lon		
³, mar	s 1 and 2 sh if Health and item 27 is m other treum		19a. Informant's Name/Relationship (7 Terri Redd-W	life	302 N	g Address (Street and Nur lorth Chape sition (Name of	1 Grate	Lane, F	pt. G B	alt. MD. 2 1229
Баппог	permit. Pages 1 Department of H Importent: If ite any injury or ot		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	cemetery, cren tro Crei	natory or other place)	200	6		ire, Maryland
D D D	permit Depar Impor any in	1-1	21. Signature of Funeral Service Licens	retrail	P		51 13K	TTOMOR	e, Triary	1and 21257
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of the timediate Cause (Final disease or condition resulting in death)	aDue to (or as a consec	2 567	ATAS	as cardiac or r	espiratory arres	st,	Approximate Interval Between Onset and Death
, 20,	certificate be executed rding physician and ise as the buriat-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease of Illy) that initiated events resulting in death) Last	c	Due to (or as a consequence of): Due to (or as a consequence of):					
O. Box 68/60	death certific e attending p id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	al death 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	lelivery Day Year
as, P	requires that the de leen signed by the a hould be detached t	by	Part II. Other significant conditions of	ontributing to death but not res		iderlying cause given in Pa	art I.			to the cause of death? Probably 4 Donknown
II Kecoras,	The law ate has b page 2 s	Completed			,			24a. Was an autopsy perform	24b. Were prior to death?	
Vital	Physiclen: this certificatal director, p	To Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2 ☐] ER/Outpatien	0.1	lace of Death (0) ice 6 □Other (<i>Sp</i>	necify)
lon or	<u>a</u>		27. Manner of Death 1 Watural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Intury	28c. Injury at Work? M 1 ☐ Yes 2	280		v inįury occurred	,
DIVISION	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, stre	eet, factory, office	28f	Location (Stre City or Town,		Rural Route Number,
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical (29a. Certifier 1 Certifying Phyone) 2 Medical Exam	vsician: To the best of my kniner: On the basis of examinating and manner stated.	owledge, death	occurred at the time, date estigation, in my opinion,	e and place, and death occurred	d due to the car at the time, da	use(s) and manner te and place, and di	as stated. ue to the cause(s)
	To the within 2 To the complete	M	29b. Signature and title of certifier	200 Afte	Jan 1	29c. License numb D 36 9	92 142	29	d. Date signed (Mod	nth. Day, Year) w 6, 2006 2 2 8
	g		B. TURAKHIA	completed cause of death (Ite	т 23a) (Тура,	Print) Rd C	gfugu	cle,	no 21.	228
3	Sta Registi		NOV 0 8 2	32. Registrar's Sign	ature	parts	4, 4,			

			For	State of Marylan			d Mental Hyg	ien@ 0 0 6	35310
			State Registrar		Certific	ate of Death		eg. No.	
	Physici	an	1. Decedent's Name (First, Middle, Las	St)	5	PENCE	2. Date of Deat	Day Year	3. Time of Death
100	/Medic	_	4a. Facility Name (If not institution, give	e street and number)	4b. C	tity, Town, or Location of D	Novembe eath	4c. County of Deat	
	- Adiiiii	9	Future Care So	and town Wine	hester L	3altimore		NA	
	Funeral		5. Social Security Number 6. S	ex 7. Age (in yrs.	last birthday) If Ur Yrs. Mont	nder 1 Year If Under 24 H hs Days Hours N	lin. (Month, Day,	Year) Co	hplace (State or Foreign untry)
	Director	a .	Usual Residence of Decedent		7 113.		NOV. 2	3,1931 191	ARYLAND
	yland		10a. State 10b. County	10c. Ci	ty, Town or Location	n	1		10d. Inside City Limits
	Ba-fs	Director	MARYLAND i)/A		DALTIMOR	RE CIT	7/	1 XYes 2 □ No
	with the	Dire	10e. Street and Number	maaaa si	7 10f.	Zip Code	5.2	Og. Citizen of What Co	ountry?
	ns 23	Funeral	11. Marital Status	12. Was Decedent Ever in U	.S. 13. Was De	ecedent of Hispanic Origin's specify Cuban, Mexican, Pi	(Specify Yes or No-	14. Race - Ame	
9	or Iter	Fun	1 ☐ Never Married 2 🕱 Married	Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give		specify Cuban, Mexican, Pi s 2 X No <i>Specify:</i>	uerto Rican, etc.)	Black, Whit	e, etc.
003	ural',	d by	3 Widowed 4 Divorced	Year or Dates:				Specify: BL	ACK
215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show wit, the Medical Exerciser must be notified at	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	16a. Decedent's U (Give kind of life. DO NO	Jsual Occupation work done during most of Tuse retired)	working	16b. Kind of Business/	Industry
212	d with giene.	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	CONSTA	RUCTION WO	RKER (CONSTRUC	TON CO.
D	be file ital Hyg of othe event,	Be C	17. Father's Name (First, Middle, Last)) - t	18. Mother's	Name (First, Middle, I	Maiden Sumame)	/
Maryland	should and Men marke umatic	ို	HENRV 19a. Informant's Nam. Relationship (ENCE	ress (Street and Number of	STILIA	City of Town State	ERSON
a Z	and 2 sl Balth and n 27 is n		ALATHA WE	BB (DAUGHTER	904 //) Inmal	1 -ST B	AITO HO	21223
ē,	一主音节	1 18	20a. Method of Disposition	20b. F	Place of Disposition (Name of or other place)	Date	20c. Location - City or	
<u><u>E</u></u>	E E E		1. ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State	RRISON.	FOREST 11	-14-060	DWINGS M.	ILLS MA.
Baltimore,	permit. Pa Departmer Important: any injury		21. Signature of Funeral Service Licer	Isee		and Address of Facility		1 .	AVENUE
	40280		23a. Part1. Enter the disease, or com	olications that caused the deal	Do not enter the			Home 2140	
	Dhysisian		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	F' , 1 =	Α	I >	,	Approximate Interval Between Onset and Death
Alger L	Physician /Medical		disease or condition resulting in death)	a. It these Seless Due to (or as a consec	(ie Wieler quence of):	Vasular o	udense		
	Examiner		Sequentially list conditions,	b					
-	Sit A Sit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	guence of):				
<u>_</u>	execul n and ial-trar	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consec	quence of):				
8760,	ficate be executed physician and Est the burial-transit	dicai	(d					
9	ertifica ling ph e as th	Med	IF FEMALE:	00-14					
Вох	eath certific attending p	cian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn. 1 Live birth 2 Feta 4 Pregnant at time of c	al death 3 □Ectopi	c pregnancy		23d. Date of del Month	ivery Day Year
P. O.	that the de led by the a detached f	hysic	1 Yes 2 No 9 Unknown	9□ Unknown		(350011)			
o. G	Se DG	by Physician/Me	Part II. Other significant conditions of		sulting in the underlying	ng cause given in Part I.	23e. Did tol	pacco use contribute to	1
ord	w require been sign	ted	Carres oes	Thagus			_ 1 □ Ye	es 2□No 3□Pr	obably 4 (Yunknown
Sec.	e law has b	Completed					24a. Was a autops	n 24b. Were au prior to med? death?	topsy findings available completion of cause of
B	hysician: The law nis certificate has t I director, page 2 s	e Co	25. Was case referred to medical				1 ☐ Yes	2 VNo 1 ☐ Yes	2 No
₹	ysicia is cert directi	To B	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3	Othor	Death <i>(Check only on</i> g Home 5 ☐ Reside	ence 6 ☐Other (Spe	c(fv)
0	ng Phys fter this neral di		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		ow injury occurred	,
sio	tendi death. tor: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not b	1	М	1 Tes 2 No	004 1 40-		
Division of Vital Records,	after of Direct Direct Jin by	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	fy)	dory, office	City or Town	reet and Number or Ru n, State)	irai Houre Number,
_	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral		29a. Certifier 1 Certifying Ph	ysician: To the best of my kno	owledge, death occur	red at the time, date and p	ace, and due to the ca	ause(s) and manner as	stated.
	the H in 24 the F nplete	Medical	one)	niner: On the basis of examina and manner stated.	_				
	Viti To	-	29b. Signature and title of certifier	alja		1) 17537	2	9a. Date signed (Mont	o. Day, Year)
•	111		30. Name and address of person who	completed cause of death (Itel	n 23a) (Type Print)	0 0 1	0 1		- 1- 1-
	171		DARSHAN S. SA	20/A 1600	W. MOUN	Thought At	ue, Kall	une My	21217
1	Sta Regist		30. Name and address of person who DAL SMAW S SAM 31. Date filed (Month, Day, Year)	2. Registrar's Sign	ature				

DHMH 17 Rev 1/2001

Registrar

NOV 0 8 2006

		For State	State of Maryla	nd / Dep		lealth and M	lental Hyg	jiene	gible.	250	110
Physicia /Medic		Registrar 1. Decedent's Name (First, Middle, Last) Nancy Ann Sch	mitt		rimeate or	Deam	2. Date of Dear Month November	Day	Year 2006	3. Time of D	Death P M
Examine	_	4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, c	r Location of Death			nty of Death		
		Manor Care Nursi	ng Home			er Spring		Mo	ntgome	ery	
Funeral	3.72	5. Social Security Number 6. Sex	M 2 TOFE	. last birthday	/) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day)	. Year)	Cour	lace (State or	Foreign
Director		322-265025	7	5 Yrs.			Oct. 19	9, 193	l Illi	.nois	
and t		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or L	ocation				1	0d. Inside City	y Limits
Maryl -f sho ied a	ρ	MD Prince	George's	Laur	e1					1 □Yes	2 No
the notif	Director	10e. Street and Number		Date	10f. Zip Code		1	0g. Citizen o	of What Cour	itry?	
h with	a a	8907 Snow Acres	Drive		20	708		U	SA		
deat	Funeral	11. Marital Status 1	Was Decedent Ever in the Armed Forces?	J.S. 13.	. Was Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No-		ace - Americ		
after or ite	Ī	1 ☐ Never Married 2X Married	1 ☐ Yes 2 🔯 No If Yes, Give		1 ☐ Yes 2 ☒ No	Specify:	riidari, etc.)	Spec	lack, White,	ite	
ours Jraľ,	d b	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:			11.2					
"natı	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Dece	edent's Usual Occup e kind of work done	ation during most of worki d)	ing	16b. Kind of			
withir ene. than he M	щ	Elementary/Secondary (0-12)	College (1-4or 5+)	iiie.	Nurse	u)			versit	y of spital	
filed Hygi other	Ö	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, I			spitar	
id be ental ked c	To Be	William	Meehan			Mabel	Γ	Denman			
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 23a-f show aumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Typ	e. Print)	19b. Mail	ling Address (Street	and Number or Rura	al Route Number	r, City or Tow	n, State, Zip	Code)	
and 2 ealth a n 27 is		James A. Schmitt/	Husband	890	7 Snow Ar	ces Drive	, Laurel	L, MD	20708		
Pages 1 and of He int: If item iny or oth		20a. Method of Disposition 1 → Burial 2 → Cremation 3 → Re	20b.	Place of Disp cemetery, cre	oosition (Name of ematory or other pla	ce)	Date	20c. Location	n - City or To	wn, State	
Pag ment ant; I ury o		4 □ Donation 5 □ Other (Specify)	Ga		Heaven Ce		/2006			ng, MD	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service License	1/			ss of Facility Do			al Hom	e, P.A	
20 = 8 g		White full	-			tt Avenue			20707		
Physician		23a. Part1. Enter the disease, or complic shock, or heart fallure. List only one Immediate Cause (Final disease or condition	e cause on each line. Pneumonia	ith. Do not er	nter the mode of dyll	ng, such as cardiac d	or respiratory arr	est,		Approximate Interval Betw Onset and Do	veen
/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):							
	_	Sequentially list conditions, b.	Dementia Due to (or as a conse	guaraa of):							
rted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence on.							
te be executed ysician and e burial-transit	Exal	that initiated events c. resulting in death) Last	Due to (or as a conse	quence of):							
be icia bur	g	L _d .									
The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the	Physician/Medio	IE ECCAMAL C.									
ith ce tendir or use	an/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	Bc. If yes, outcome pf pregr 1 ☐ Live birth 2 ☐ Fet		□Ectopic pregnanc	y			Date of delive		SLUT
ie dez the at ned fo	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of 9□Unknown	death 5	Other (specify)			1	Month	Day Ye	ear
w requires that the d been signed by the should be detached		Part II. Other significant conditions cont	tributing to death but not re	sulting in the	underlying cause giv	en in Part I.	23e. Did tob	nacco use co	entribute to th	e cause of de	eath?
sign d be	d b									ably 4 ∐Ur	
w req been shou	Completed						24a. Was a	n 24h	. Wore auto	osy findings a	vailable
The lav	dmo						autops perforr	ned?	prior to cor death?	npletion of cau	use of
ician: Th certificate rector, pag		25. Was case referred to medical				26. Place of Death		2 X No	1 ☐ Yes	2 No	
ysician: is certific director,	To Be	examiner?	ospital: 1 ☐ Inpatient 2 ☐]ER/Outpatie	ent 3 DOA Oth				ther (Specifi	()	
ding Phys h. After this funeral dir	.:	27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	of 28c. Injui		28d. Describe ho			·	
eath.	atic	2 ☐ Accident Investigation			M 1□	Yes 2 □ No					
or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Spec	nome, farm, st ify)	treet, factory, office	1	28f. Location (St. City or Town	reet and Nun n, State)	nber or Rura	l Route Numb	er,
	Medical Co	29a. Certifier (Check only one) 1 ☑ Certifying Physical Examin	ician: To the best of my kner: On the basis of examin and manner stated.	owledge, dea ation and/or i	th occurred at the tinnvestigation, in my o	me, date and place, opinion, death occurr	and due to the ca ed at the time, d	ause(s) and r late and place	manner as st e, and due to	ated. the cause(s)	
To th To th comp	Me	29b. Signature and title of certifier	1/		29c. Licens		2	9d. Date sigr	ned (Month, i	Day, Year)	
9		Manne &	Her		005	13235		11/6	106		
20 1	Ì	30. Name and address of person who con							-		
		Darryl A. Hill, M.	.D. 13635 Ba	altimo:	re Avenue	, Laurel,	MD 2070	7			
Stat Registra		31. Date filed (Month, Pay, Year)	32. Redistrar's Sign	lature American	9 - 00 -						

			For State	State of Ma	aryland / D	epa Cert	rtment of H <i>tificate of L</i>	ealth and M Death	lental Hy	giene Reg. No.		35313
			Registrar 1. Decedent's Name (First, Middle, La.	st)			inouto or L	Journ .	2. Date of De	eath		3. Time of Death
	Physicia		Kiran Jyot	i Sharma					Month Nov.	Day 2	2006	0842 hrs
	/Medic Examin		4a. Facility Name (If not institution, give			T	4b. City, Town, or	Location of Death	110 / 1		County of Deat	
	Exami	٠.	Shady Grove Adve	ntist Hosp	ital		R	lockville			Mon	tgomery
	Funeral		5. Social Security Number 6. S	ex 7. Age	(In yrs. last birt	hday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	rth		hplace (State or Foreign untry)
	Director		040-62-4342	□M 2XF	57	rs.	WOTHIS Days	Tiodis Iviii.	June 1	5, 1	949	India
	pu *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	orloc	ation					10d. Inside City Limits
	eho	5			out, com							1 □ Yes 2 ☑ No
	the M	Directo	Maryland Mon 10e, Street and Number	tgomery	771-71	Po	10f. Zip Code			10a Citi	zen of What Co	
	with B or		10508 Beechknoll	Tomo			Tot. Zip code	20854		rog. Om		·
	ne 23	Funeral	11. Marital Status	12. Was Decedent B	Ever in U.S.	13. W	as Decedent of Hi		ecify Yes or N	0-	UNITED 14. Race - Ame	States rican Indian,
	r Iten	F	1 ☐ Never Married 2 ☑ Married	Armed Forces?				spanic Origin? (Spi n, Mexican, Puerto	Rican, etc.)		Black, White	e, etc.
3	el', o Exan	þ	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2√ N If Yes, Give 1 Year or Dates:		1	☐ Yes 2\(☐ No	Specify:			Specify: As:	ian-Indian
215-0036	d within 72 hours after deeth with the Maryland piene. rr than "naturel", or Iteme 23a or 28e-f ehow The Medical Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest gra		16a.	Decede	ent's Usual Occupa	ation during most of work	ina	16b. Ki	nd of Business/	Industry
7	tthin	nple	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. D	O NOT use retired)	9			
7	0 0 2	Co		5+		Reg	istered				Health (Care
Maryland	® a b ≥	Be	17. Father's Name (First, Middle, Last,					18. Mother's Name			Sumame)	
$\frac{3}{2}$	should by	2	Gurdial Chand						sh Sha			
<u>ā</u>	12 sho h and 7 is m	1	19a. Informant's Name/Relationship (and Number or Run				(ip Code)
	s 1 and 2 should if Heelth and Men Item 27 is marks other traumatic	1 3	Kewal K. Sharma/1	nuspand	20b. Place of	Dispos	Beechkno ition (Name of atory or other place	11 Lane	Potoma Date		20854 cation - City or	Town State
و			1 Burial 2 XCremation 3		1			1				
altimore,	it. Propression of the property of the propert		4 □ Donation 5 □ Other (Specification 21. Signature of Funeral Service Licer		West Ar		el Crema Name and Addres	tory 11/C	04/06	Ude	enton, N	4D
Ra	permit. Page Department of Important: If eny injury or once.			modeo		Do 14	naldson 11 Annap	Funeral H olis Rd.	lome & Odento:	Crema n, MI	etory _l 3 ^E	P.A.
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death. Do n	ot ente	r the mode of dying	g, such as cardiac o	or respiratory a	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition				an Cance					Onset and Death 6 yrs 10 mo
	/Medical		resulting in death)	u	a consequence o							0 /10 10 110
	Examiner	L	Sequentially list conditions,	b								
	ed sit	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (or as	a sensupeence a	H):						
_	and and II-tran	хап	that initiated events resulting in death) Last	c. Due to (or as a	a consequence o	of):						
9	ficate be executed physicien and s the burial-transit											
09/89	ficate phys s the	edical		_ d								
XOA	eath certifi attending I for use as	/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		_					23d. Date of deli	ivery
ň	law requires that the death cert es been signed by the attending 2 should be detached for use a	Physician/M	in the past 12 months? 1 ☐ Yes 2 XNo	4☐Pregnant at	2 ☐ Fetal death time of death		Ectopic pregnancy Other (specify)				Month	Day Year
л Э	at the de by the a	hys	9 Unknown	9□ Unknown					_			
	w requires that been signed t should be det	by P	Part II. Other significant conditions of	ontributing to death bu	ut not resulting in	the un	derlying cause give	en in Part I.	23e. Did	tobacco u	se contribute to	the cause of death?
ğ	equire en sig		Respiratory Fa	ilure					1 🗆	Yes 2	No 3□Pr	obably 4 Unknown
ပ္က	law re	plet							24a. Was	s an	24b. Were au	topsy findings available completion of cause of
ř	hysician: The la nis certificate hes I director, page 2	Completed							perf	ormed?	death?	2[X] No
<u> </u>	ilan: artifica ctor. p	Be C	25. Was case referred to medical examiner?					26. Place of Deat				
<u>-</u>	hysic his ce I dire	To	1 ☐ Yes 2 ☒ No	Hospital: 1 Inpatie	21		3□ DOA Othe	er: 4 🗆 Nursing Ho	me 5□Res	idence (3 □Other (Spec	cify)
_ _	Attending Physician: or death. ector: After this certific by the funeral director.		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y Year) 28b. T	ime of njury	28c. Injury Work		28d. Describe	how injur	y occurred	
<u> </u>	Attendle death. ctor: A y the fu	catl	2 Accident investigation 3 Suicide 6 Could not be					Yes 2□No		-		
Division of Vital Records,	after of Direct of in by	Certification:	4 Homicide determined			rm, stre	et, factory, office			(Street an own, State		ural Route Number,
	lospite hours uneral	edical C	29a. Certifier (Check only 2 Medical Exer	ysician: To the best on niner: On the basis of	of my knowledge	, death	occurred at the timestigation in my or	ne, date and place,	and due to the	cause(s)	and manner as	stated.
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	Med	one) 29b. Signature and title of certifier	and manner sta			29c. License				e signed (Monti	``
	- s + ō		· Onle	Mer	w		рзз	3224		Nov	ember 2	2006
Ŋ			30. Name and address of person who	completed cause of de	eath (Item 23a) (Type, P				1100	cmber Z	, 2000
1)		Ram Trehan 1400	Forest G1	en Road	#43	35 Silver	Spring.	MD 20	910		
	Sta		31. Date filed (Month, Day, Year)	32. Pogistra	ar's Signature	A	nelle)					
	Registr	ar	NOV 0 8 2	2006 Meses	us Do	Jag .	Acres					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc 2864 2-7-07 vt. State of Maryland / Department of Health and Mental Hygiene 0 6

35314 For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) Derelle Kathleen Schwager 2. Date of Death Month 3. Time of Death Physician November 4, 2006 Katherine Schwager 10:45am M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Greater Baltimore Medical Center Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛛 F 181-30-7346 Yrs 16,1939 Director 67 June Phila., PA. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show 1 ☐ Yes 2 No Maryland Baltimore County Timonium Direct 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Items 23a 231 Castletown Road 21093 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ဩ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 6 1 ☐ Yes 2 No þ Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural" Completed other than "natur 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Service Tech. n/a General Instruments 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Is marked unk. unk. 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit Pages 1 and 2 s Department of Health ar Important: If Item 27 Is any in ury or other trau once. Ms.Novella V. Drammis (Friend/Ex.) 231 Castletown Road Timonium, Maryland 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ⚠ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evans Funeral Chapel | Nov.06,2006 Forest Hill, Maryland 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Ctr., P.A.
2325 York Road Timonium, Maryland 21093 21. Signature of Funeral Service Licensee Br Rad 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 1-170×10 nours /Medical Due to (or as a consequence of) Examiner .Una MINCOR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed physician ar Due to (or as a consequence of): .O. Box 68760, by Physician/Medical ettending I IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the e 9 Unknown 9 Hinknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably been si should I 1 ☐ Yes 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificete has b irector, page 2 s autopsy performed? 2☐No 1 Yes 25. Was case referre medical examiner? Be 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA his After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours efter To the Funeral Dire To the Hospitel 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1763317 M. D November 4,2006 Name and address of person who completed cause of death (Item 23a) (Type, Print) MASS. MD GBM(Purson, MD 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar NOV 0 8 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygien 2006 35315

	1	State Registrar		-	Ce	rtificate of	Death		Reg. No.		
Physiciar /Medica		1. Decedent's Name (First, Middle, L Ruth Athaline Sc	•					2. Date of D Month Novemb	Day	Year 2006	3. Time of Death
Examine	r	4a. Facility Name (If not institution, gareater BALTIMO	RE MEDICAL	CEN		TOWSON	r Location of Dea	th	4c. C BAI	ounty of Death	
Funeral Director		5. Social Security Number 6. 358-09-3870 Usual Residence of Decedent	Sex 7. Ag 1 ☐ M 2 1 F	e (In yrs. 8)	(ast birthday) (Signal Yrs.)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		irth 2, 192(Cou	place (State or Foreign htry) ago, II
death with the Maryland ome 23a or 28e-f show ir must be notified at	Funeral Director	10a. State 10b. County Maryland Baltin 10e. Street and Number	nore		y, Town or Lo				10g. Citize	en of What Cou	1 Od. Inside City Limits 1 ☐ Yes 2 No
th with	a D	24 Hillside Aver	nue			21030				ed State	•
J36 urs after ll', or its	2	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 244 If Yes, Give Year or Dates:	_		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 X No		Specify Yes or N to Rican, etc.)		Race - Ameni Black, White, Specify: Whi	etc.
within 72 hc ene. than "netur	Сотріете	15. Decedent's (Specify only highest g	Education rade completed) College (1-4or:	5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired Maker	ation during most of wo	rking		of Business/In	dustry
s 1 and 2 should be filed within if Heelih and Mental Hygiene. Item 27 is marked other transitionalic event, Item Market treumelic e	Be Con	12 17. Father's Name (First, Middle, Las	N/A	,	none	maker		me (First, Middl	e, Maiden S	n Home	
d Ment d Ment narked netice	0	Charles Fred Ful			405 14:00		Verna Wa				
Heelth and tem 27 is m		19a. Informant's Name/Relationship Miss Donna South 20a. Method of Disposition		20b. P	24 H	sition (Name of	venue, C		ille,		nd, 21030
Pages lent of nt: If It		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		0	emetery, crei	matory or other plac		8,2006		•	, Maryland
permit. Pages Depertment of I Important: If Ite eny Injury or of gace.		21. Signature of Funeral Service Lice	Lezm		2	Name and Addre	ss of Facility				on Ctr.,P.A 1093
Physician /Medical Examiner	Examiner	23a. Pan1. Enter the disease/ or coshock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequenually list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury)	ly one cause on each li	ne. Ses 7 a consequ	uence of):	HEALT			arrest,	6	Approximate Interval Between Onset and Death MONTH
ettending physicien and for use as the burial-transit	Medical Exa	that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant	Due to (or as d	of pregna	ncy				23	d. Date of delive	an
been signed by the ettend should be detached for us	Completed by Physician	in the past 12 months? 1 Yes 2 No 9 Unknown	1□Live birth 4□Pregnant a 9□Unknown			Ectopic pregnancy Other (specify)				Month	Day Year
ed of the delivers in a second per ed pluo	ted by r	Part II. Other significant conditions	contributing to death b	ut not resi	ulting in the u	nderlying cause giv	en in Part I.		tobacco use	1	ne cause of death?
certificate has be rector, page 2 sh	Сошріє							24a. Waa auto pen 1 ∐ Yes	s an opsy ormed?	24b. Were auto prior to co death? 1 Yes	ppsy findings available impletion of cause of 2 No
for Attending Physicien: The law requires that the death celler death. Director: After this certificete has been signed by the ettent in by the funeral director, page 2 should be detached for us	D D	25. Was case referred to medical examiner?	Hospital:			nt 3 DOA Oth	oc	ath (Check only			
	ation: 10	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigati	28a. Date of Inju (Month, Da		ER/Outpatier 28b. Time o Injury	f 28c. Injur		dome 5 Res			ý)
To the Hospitel or Attending I within 24 hours eiter death. To the Funeral Director. After completely filled in by the funeral Director.	Certification:	3 Suicide 6 Could not 4 Homicide determine		ury - At ho c. (Specify	ome, farm, str	reet, factory, office		28f. Location City or To	(Street and I own, State)	Number or Rura	al Route Number,
To the Hospitel To the Funeral I completely filled	Medical	one) 2 Medical Exe	Physicien: To the best eminer: On the basis o and manner st	f examinal	wledge, deat tion and/or in	vestigation, in my o	pinion, death occ	e, and due to the urred at the time	, date and p	lace, and due to	the cause(s)
To COT	2	29b. Signature and title of certifier	ATTEN	DIN	6	29c. Licens	0255	38	29d. Date :	signed (Month,	Day, Year)
State	9	30. Name and address of person who PETER STAN 31. Date filled (Month, Day, Year)	o completed cause of c	5	3 20	BELLON	a Ave	SUIT	e120	Touse	~MD 21204
Registral	r	NOV 0 8 20	06	1	A Sign	rofe?	***************************************				

DHMH 17 Rev 1/2001

		ľ	For State Registrar	State of I	Marylan	•		f Health a of Death	nd Me	ntal Hygie	ne 006	35316
П	Dhuaisi		1. Decedent's Name (First, Middle, Las	,					2.	Date of Death	Day Yea	3. Time of Death
п	Physici: /Medic	6	Elizabeth Pri							Nov.	4 200	6:30p. [™]
	Examin	er	4a. Facility Name (If not institution, give 25 Ruxview Cour				4b. City, Tow	n, or Location of S on	f Death		4c. County of De Baltin	
	Funeral		5. Social Security Number 6. Security Number 1	9x 7. □M 2√□F	Age (In yrs. 89	last birthday) Yrs.	If Under 1 Y Months Da	ear If Under 2 tys Hours	Min. T	Date of Birth (Month, Day, Y an. 5,19	(ear) 9.8	irthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	Λ	09				J,	an. 5,19	1/ V1	rginia
	how how		10a. State 10b. County			y, Town or Lo	cation					10d. Inside City Limits
	he Ma	Director	Maryland Baltimo	re	T	owson	10f. Zip Co			100	. Citizen of What	1 Yes 2 No
	3a or		25 Ruxview Court					204		109	U.S.A.	Cobinity?
	death	Funeral	11. Marital Status	12. Was Decede		.S. 13. V	Vas Decedent	of Hispanic Orig Cuban, Mexican,	jin? (Specif	y Yes or No-		nerican Indian,
36	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "natural; or Itams 23a or 28s-f ehow event, the Modical Examiner: ust be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □Yes 2] If Yes, Give Year or Date	ŽΝο		☐ Yes 21X				Specify:	White
215-0036	2 hour	ted t	15. Decedent's Ed	ucation	5.	16a. Deced	ent's Usual O	ocupation		16	b. Kind of Busines	
212	ithin 7	Completed	(Specify only highest gra	College (1-4)	or 5+)	life. L	OO NOT use re		of working			
121	filed wi Hygien Sther th		17. Father's Name (First, Middle, Last)			Но	memake		r's Name (F	First, Middle, Ma	Own Ho	ome
Maryland	should be filed nd Mental Hygin marked other matic event, I	To Be	Fenton	Pr	iest			Augus		risi, middie, ma	Bull	
ary	should be and Mental Is marked o	ř	19a. Informant's Name/Relationship (7			19b. Mailin	g Address (St			Route Number, C	City or Town, State	
	s 1 and 2 should of Health and Men Item 27 is marke other traumatic		Russell Stevenson	Jr.(Son		733	Dividi	ng Road	Seven	na Park	,Marylar	rd 21146
altimore,	Pages 1 nent of He int: If Ites iry or oth		20a. Method of Disposition 1 Burial 2 A Cremation 3		te C	lace of Dispos emetery, crem	sition (Name o natory or other	place)	Date	9 20	c. Location - City of	or Town, State
=======================================	글론원들 .	1	4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen		Gre	en Mou	nt Crei	matory 1	(11-/-()6 <u>F</u>	Baltimore lefeld F.	II T.
B	Depa Impo any i		1 (Shent)	nat		1						and 21212
ı			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that cause on Jack	sed the death	h. Do not ente						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a	40 crs	dil	Infa	rcto	-			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a consequ	vence of):	A - L	24	Nic	0 - 2 2		unknown
	•	ler	Sequentially list conditions if any, leading to immediate	b. Due to (or	as a consequ	uenc:	// (10.5	24.84		Canada
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c.		- 4						
8760,	icate be executed physician and s the burial-transit	al Ex	resulting in death) Last	Due to (or	as a consequ	uence of):						
287	ficate I physi s the b	edical		d								
XO	death certifi e attending I id for use as	In/M	230. Was decedent pregnant	23c. If yes, outcom	ne of pregna	ancy	Ectopic pregn	3500			23d. Date of d	delivery
J. Box	0 0 0	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnan 9□Unknow	t at time of de		Other (specif)				Month	Day Year
о. О	that the ed by detact	Phy	Part II. Other significant conditions or	ontributing to deat	h but not resi	ulting in the un	derlying cause	given in Part I.		23e. Did tobac	cco use contribute	to the cause of death?
rds,	Attanding Physician: The law requires that the de in death. It death. ector: After this certificate has been signed by the set the funeral director, page 2 should be detached.	ed by	Hypertens, on	h						1 🗆 Yes	2 ⊡No 3 □	Probably 4 □Unknown
000	law re- as bee 2 sho	Completed	Cerebrovace	Nat Di	sure					24a. Was an autopsy	24b. Were	autopsy findings available o completion of cause of
ř	Physician: The lav this certificate has al director, page 2	Com								performe 1 ☐ Yes 2 ☐	d2 death	es 2 No
Ĭ Š	lecian: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:				Othor		Check only one)		
ō	iding Phys th. : After this funeral di	.T	1 Yes 2 No 27. Manner of Death	28a. Date of I	niury	ER/Outpatient 28b. Time of		4 □ Nur Injury at Work?		5 Residence 1. Describe how	injury occurred	pecify)
Ö	ath. pr: Aft	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		Day Year)	Injury		Work? 1 ☐ Yes 2 ☐ N	10			
Division of Vital Records,	F 8 F C	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of	Injury - At ho etc. (Specify	ome, farm, stre	et, factory, of	ice	28f	Location (Stree City or Town, S		Rural Route Number,
	lospital hours e uneral (29a. Certifier 1 Certifying Ph	vsician: To the be	st of my kno	wledge, death	occurred at th	ne time, date and	d place, and	due to the caus	se(s) and manner	as stated
	T 4 F F	edical	(Check only 2 Medical Examone)	niner: On the basi and manner	s of examina	tion and/or inv	estigation, in r	ny opinion, deatl	h occurred	at the time, date	and place, and d	ue to the cause(s)
	To the within 2	Σ	29b. Signature and title of certifier	20.	/			cense number			. Date signed (Mo	
	1		PW: The W	7 run	·~	mm !	مرب	D4:	719	9	Nov.	6)2006
1	0		30. Name and address of person who compared to the second	lalona	211	630	rint)	cher	les	52	Nov. Belti	non
	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 8 2006	32. Reg	strar's Signa	ture	E.					
	negisti	ui	0 0 2000	J-26 11 10	and the	Par promise	Market Comments					

Physician /Medical Examiner 1. Decedent's Name (First, Middle, Last) Edward J Salichs 4a. Facility Name (If not institution, give street and number) Salichs 4a. Facility Name (If not institution, give street and number) Funeral Director Funeral Director Paryland Baltimore 1. Decedent's Name (First, Middle, Last) Figure 1			•	1 - For State Registrar	State of Marylar		artment of H rtificate of I		Mental Hy	giene Reg. No.	006	35317	
Exemination of Residual Land Scale (Control of Control					st)	-				eath	Vear	3. Time of Death	
Examinor 4. Fields and The Courty of Dates in Court of Court of Dates and Courty of Dates in Court of Dates and Courty of Dates in Court of Dates and Courty of Dates in Courty of Date	П			Edward J S	alichs		, -		NOVEM	BER .	3,2006	11:00₽	
Directory Control Con		Examin	er	4a. Facility Name (If not institution, give Saint Joseph	e street and number) Nedical Ce	nter	4b. City, Town, or			4c. C	,	timore	
10.5 State 10.0 County 1						• • • • • • • • • • • • • • • • • • • •				rth 191 8	9. Birthp Cour Ponce	place (State or Foreign	
State Stat		and w			10c. C	ity, Town or Lo	ocation					10d. Inside City Limits	-
State Stat		Maryl F aho	tor	Maryland Baltimore	Ba	ltimore	County					1 ☐ Yes 2 No	
State Stat		or 288	lrec	10e. Street and Number								ntry?	
State Stat		ath wi	ral		Y	10			2 1 1				_
State Stat	36	rs after de l', or frema Xandrier d	by Fune	1 ☐ Never Married 2XXMarried	Armed Forces? 1757Yes 2 ☐ No If Yes, Give		If Yes, specify Cuba	Specify:	nto Rican, etc.)		Black, White,	etc.	
State Stat	9	2 hou	ted		ducation	16a, Dece	dent's Usual Occup	ation		16b. Kind			-
State Stat	121	within 7 ene. than "r	omple	Elementary/Secondary (0-12)	College (1-4or 5+)			during most or w	orking .	Socia	1 Securit	v Administrat	i
Physician Medical Examiner The Physician Medical Examiner Th	d 2	e filed if Hygi other				, CLCL	TOTAL HOLLES	18. Mother's N	ame (First, Middle			<i>J</i>	_
Physician Medical Examiner The Physician Medical Examiner Th	ylai	Menta Menta arked	ToE										_
Physician Medical Examiner The Physician Medical Examiner Th	Mar	d 2 sh th and th and traum			Type, Print)								
Physician Medical Examiner The Physician Medical Examiner Th		is 1 and Heal of Heal item 2		20a. Method of Disposition	I	Place of Dispe	osition (Name of	T					
Physician Medical Examiner The Physician Medical Examiner Th	<u><u>E</u></u>	Page ment c ant: If ury or				Joseph	Church Cem.	November	7 2006	Baltir	more, Mary	land	
Physician (Modical Examiner) 22	Balt	permit. Depart import any inj		21. Signatur of Funeral Service Lios	1586 1586 1586 1586 1586 1586 1586 1586	1	assahn tune	eral Home		vland '	21236		
Physician (Modicial Examiner The property of the property of				23a. Part1. Enter the disease, com shock, or heart failure. List only	plications that caused the dea one cause on each line.	ath. Do not en	ter the mode of dyin	ig, such as cardi	ac or respiratory a	irrest,	EXESO	Interval Between	
Sequentially list conditions, cause. Enter Underlying Cause. Disease of religion to a sequence of the cause of death? Sequentially list conditions, cause. Enter Underlying Cause. Enter Underlying Cause. Enter Underlying Cause. Enter Underlying Cause. Enter Underlying Cause. Enter Underlying Cause. Enter Underlying Cause. Enter Underlying Cause. Enter Underlying Cause. Enter Underlying Cause (Disease of religion)				disease or condition	a								_
State St					Due to (or as a conse	quence of):							
Section Part			ner	Sequentially list conditions, flarly, leading to infinediate cause. Enter Underlying	b. Use to (or as a nonse	quanna of):						· · · · · · · · · · · · · · · · · · ·	_
Section Part	1	ecutec and -transi	cami	that initiated events	C. Due to (or as a conso	quanca of):							_
FFEMALE 236. Was seedednt pregnant 1 236. Was seedednt pregnant at time of death 2 2 2 2 2 2 2 2 2	760,	e be ex /sicien e burial	calE		d.	quarica or).							
1 Yes 2 No 3 Probably 4 Unknown 24a, Was an 24b, Were autopsy findings available prior to completion oil cause of death? 1 Yes 2 No 25. Was case referred to medical examiner? 25. Was case referred to medical examiner? 25. Was case referred to medical examiner? 25. Was case referred to medical examiner? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 28a. Set of Injury 28b. Time of Inj	9		Medi	IE EEMALE.							II.		
1 Yes 2 No 3 Probably 4 Unknown 24a, Was an 24b, Were autopsy findings available prior to completion oil cause of death? 1 Yes 2 No 25. Was case referred to medical examiner? 25. Was case referred to medical examiner? 25. Was case referred to medical examiner? 25. Was case referred to medical examiner? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 28a. Set of Injury 28b. Time of Inj		the death ce the attendii ched for use	yslcian/N	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 ☐ Fet 4 ☐ Pregnant at time of	al death 3				23			
25. Was case referred to medical aximiner? 26. Place of Death (Check only one) 27. Manner of Leath (Month, Day Year) 28. Manner of Leath (Month, Day Year) 28. Dime of Injury at Work? 290. Certifier (Check only) one) 281. Decarding investigation and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 290. Dime of Injury at Work? 291. Decarding investigation and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 292. License number 293. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 294. Date signed (Month, Day, Year) 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature	<u>α</u>	quires that I in signed by uld ba deta		Part II. Other significant conditions of	contributing to death but not re	sulting in the u	ınderlying cause gıv	en in Part I.			,		
The state of least to the state of least to the state of large of	l Reco		Complet						auto perf	opsy ormed2	prior to co death?	emptetion of cause of	
The state of least to the state of least to the state of large of	Vita	iclan: certific ector.	Be	examiner?	Hospital:		Oth	ec					
The state of the s	ō	Phys this ral dii		27. Manner of Death	28a. ate of Injury	28b. Time o	nt 3L DOA	4 Nursing				fy)	-
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LILIA CEBALLOS M. D. 7601 OSLER DRIVE TOWSON, MARYLAND 212014 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature	ion	ath. ath. ir: Afte	ation	2 ☐ Accident investigation	n	Injury							
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LILIA CEBALLOS M. D. 7601 OSLER DRIVE TOWSON, MARYLAND 212014 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature	Divis	after de Directo	ertific	determined	286. Place of injury - At i	home, farm, st	reet, factory, office				Number or Rura	al Route Number,	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LILIA CEBALLOS M. D. 7601 OSLER DRIVE TOWSON, MARYLAND 212014 State 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature		Hospita 24 hours Funeral etely fille	dicai	(Check only 2 Medical Exar	niner: On the basis of examin	nowledge, dear nation and/or in	th occurred at the tire	ne, date and pla pinion, death oc	ce, and due to the curred at the time	cause(s) a , date and p	ind manner as solace, and due t	stated. o the cause(s)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LILIA CEBALLOS M. D. 7601 OSLER DRIVE TOWSON, MARYLAND 212014 State 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature		То th within То th сопр	Me	29b. Signature and title of certifier	00		29c. Licens	e number			-		_
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature 32. Registrar's Signature) (obc	Ulp, my		D25	886		No	4.3-	400 G -	
State 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature		DT'			/			TOWSON	, MARYL	ann.	21204		
					32. Registrar's Sign		Carlo		,				

DHMH 17 Rev 1/2001

			For State		Sta	ate of M	1arylan		partment			and M	lental H	ygiene		-		_
	-		Registrar 1. Decedent's Nam	o /First Middl	o (act)		· · · · · · · · · · · · · · · · · · ·	Ce	ertificate	of L	Jeath		2. Date of I	Reg. No	201	16	3 5 3	8
	Physicia /Medic		I d a	ie (Filst, Middi	e, Lasi)	Falv	o	Sme	ellows	к у			Month	Da	8,200 ^{Ye}	ar	1:44PM M	
25	Examin	_	4a. Facility Name (Location o	of Death			County of [
~			5. Social Security I		Edgeme 6. Sex			last hirthda	Camp If Under	_	ings If Under:	24 Hrs	8. Date of f		rince		rge's ace (State or Foreign	
	Funeral Director		233-36-86		6. Sex 1 □ M 2		nge (In yrs 79	Yrs.	Months	Days	Hours	Min.	Dec.	Day, Year)		Count	Virginia	
	ס		Usual Residence of	of Decedent									Dec.	+, 17.	20 1			_
	arylan show d at	_	10a. State	10b. County		- 1 -	10c. City	y, Town or I								10	d. Inside City Limits 1 ☐ Yes 2€ No	
	he Ma 28a-f s otifie	Funeral Director	Maryland		Georg	ge s		Cai	np Spr					10= Cit	izen of Wha	1 Count		_
	with t a or 2 t be n	ä	10e. Street and Nu 6716 Edg		Drive				10f. Zip		20748			Tog. Cit	U.S.		ıy?	
	ns 23 musi	era	11. Marital Status	gemer e	12. W	as Deceden	t Ever in U.	S. 13	3. Was Deced If Yes, spec				cify Yes or I	No-	14. Race - /	America		-
320	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Fur	1		ried 1	rmed Forces ☐ Yes 2 X Yes, Give ear or Dates] No		If Yes, spec		Specify:	i, Puerto	Rican, etc.)		Black, \ Specify:			
5-0036	72 hou natura lical E	eted	(Sne	15. Deceder	it's Education	nleted)		16a. Dec	edent's Usua	l Occupa	ation	t of worki	ina	16b. K	ind of Busin	ess/Ind	ustry	_
7	ithin 7 ne. nan "r	Completed	Elementary/Sec			ollege (1-4o	r 5+)		ve kind of wor . DO NOT us taffing				ng	For	dera1	Cov	ernment	
7	led wi Hygier her th	S	12th 17. Father's Name	/ First Middle	(act)				Callin	5 DP			(First, Midd			GUV	er Hilleri t	_
yland	the find the find the column of the column o	Be	Pietro		1 vo									_				
Ž	should nd Me mark matic	ြ	19a. Informant's N			rint)		19b. Ma	iling Address	(Street a			etta al Route Nur	Sca nber, City o		te, Zip	Code)	-
<u>a</u>	nd 2 salth al		Nina Ma	arcelli	no (da	ughte	r)	103	3 Color	y C	rossi	ng E	dgewat	er, l	Maryla	nd	21037	
e,	ss 1 a of Hea item		20a. Method of Dis		. □ D	-1 (0)		Place of Dis	position (Namerematory or or	ne of		Nov.			ocation - City			_
Ē	Page nent ant: If ury o		4 □Donation	Cremation 5 ☐ Other (5	Specify)	ai from Stat	Re		ction (tery	20	06	Cli	nton,	Mar	yland_	
Baitimor	permit. Departi Imports any Inj		21. Signature of F	uneral Service	Licensee	I m	0025	7	22. Name and				e Fune a Feri		-		n, Md 2073	5
ı			23a. Parti. Enter shock, or he	the disease, o	r complication	ns that caususe on each	ed the deat	h. Do not e	enter the mode	e of dyin	g, such as	cardiac c	or respiratory	arrest,			Approximate Interval Between	
	Physician		Immediate Cause disease or conditi	on	a	Meta	statio	c Can	cer								Onset and Death	
1	/Medical Examiner		resulting in death))		Due to (or a				10						.,	7 - 14 -	
	Lammer	_	Sequentially list o	onditions,	b	Lung Due to (or a	Cance									1	months	_
/	ted nsit	nine	Sequentially list c if any, leading to i cause. Enter Und Cause (Disease o that initiated even	mmediate lerlying or injury	₹	Due to (or e	is a conseq	derice oi).										
,	execunand and all-train	Examiner	that initiated event resulting in death)	ts Last	c	Due to (or a	as a conseq	uence of):										_
8/60,	cate be executed physician and the burial-transit	dical			L d													
9	rtifical ng phy as th	Nedi	IE CEMALE.															_
C. Box	The law requires that the death certifi te has been signed by the attending age 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decede in the past 1: 1 ☐ Yes 2 9 ☐ Unknow	2 months?	1 4	yes, outcom □Live birth □Pregnant □Unknown	2 ☐ Feta at time of d	death 3	B⊟Ectopic pr 5⊟ Other <i>(sp</i>					-	23d. Date o Month		y Day Year	
	s that ned by deta	by Pr	Part II. Other sign	nificant condit	ions contribu	ting to death	but not res	ulting in the	underlying ca	ause give	en in Part I		23e. Di	d tobacco	use contribu	te to the	e cause of death?	
g	equire en sig												15	Yes 2	□ No 3[☐ Proba	ably 4 □Unknown	
Hecords,	sician : The law re certificate has bev rector, page 2 shc	Completed					=							rtopsy erformed?	prio dea	r to con th?	osy findings available apletion of cause of	
Vital	clan: ertifica ctor, l	Be C	25. Was case refe examiner?	erred to medica								of Death	n (Check onl	A.A.				_
0	hysic this o	٩	1 ☐ Yes 2 2		Hospit	I 🗀 Inpa		ER/Outpat			4 ⊔ NU		me 5 X XR			Specify)	_
	ding F I. After funera	ion:	27. Manner of Dea	5 ☐ Pendi	ng	Ba. Date of Ir (Month, L	Day Year)	28b. Time Injur	y M	8c. Injun Work	yat k? Yes 2∐		28d. Describ	e how inju	ry occurred			
DIVISION	Attende death death ctor:	ficat	2 ☐ Accident 3 ☐ Suicide	6 ☐ Could		e. Place of i	injury - At he	ome, farm,	street, factory				28f. Location	n (Street al	nd Number o	or Rural	Route Number,	_
2	afor / after I Dire d in b	Certification:	4 ☐ Homicide	deteri	Illined	building,	etc. (Specif	fy)						Tòwn, State				
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	Medical C	29a. Certifier (Check only one)		Examiner: (of examina		ath occurred investigation									_
	To the within To the Comp	Me	29b. Signature an	d title of certific	i .						e number	2 -			ite signed (A		**	_
	1) je	~ l	ren		MD			115	28-	50		NO	vem b	er.	3,2006	
	H		30. Name and add	dress of persor		>	90	00 Bes	stgate		d Sui	te 30	00 Ann	apoli	s, MD	214	401	_
	Sta Registi		31. Date filed (Mo	onth, Day, Year		32. Regi	ar's Signa	ature	Span									
									- 07									

Please Type or Print in Black Indelible Ink

Reginald A. Seals	1	- For State	tate of M	aryland /		tment of			Menta	al Hy		eg. No.	nn	6 3	531
Physiciar Medical Examin	1/	Registrar 1. Decedent's Name (First, Midd Reginald	le,Last)	A			eals			2	2. Date of Deat Month November	th	3	3. Time of De	eath
		4a. Facility Name (if not instituti 270 N south of Mud	-				4b. City, To Rockv		ocation of			4c. County of Montgom			
Funeral Director		5. Social Security Number 246–19–3833	6. Sex		(in yrs. la:	st birthday) Yrs	If Under Months	_	If Under Hours	24Hrs. Min.	1	th(MM/DD/YYYY) 1-1966	Foreign	place (State htry) N.C	
d how any ce.	_	Usual Residence of Decedent 10a. State 10b. County N.C. Cum	berland	đ	10c. City,	fown or Locat Fayet	ion :tesv:	ille						10d. Inside C	
ith the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number 1408 Waterle	ss St.	,			10f. Zip (3306			1	0g. Citizen of Wha	t Countr	y?	
er death w	by Funeral		vorced If Yes, or Date	Give Year	No	If Y	es, specify Yes 2	Cuban,	Mexican, F	Puerto F		14. Race - White, Specify:	etc. Bla		ack,
5-0036 Hed within 72 hourr Hygenen other than "natu the Medical Exan	mpleted	15. Decedent's Education (Sp Elementary/Secondary (0-12 12th grade) Co	est grade com llege (1-4 or 5 2 yrs	5+)	during m	ost of work	ing life. I	DO NOT u	se retire	ed)	Commeri		•	Drive
Battimore, MD 21215-005 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other thingury or other traumatite event, the Median prints of the traumatite event, the Median prints of the traumatite event, the Median prints of the Median pr	Be C	17. Father's Name (First, Middle Lamart 19a. Informant's Name/Relation			Kurvi		Address			Glad	dys	Maiden Surname) Se	als	Zin Code)	
9, MD 2 and 2 shou dealth and N item 27 is n traumatic	٩	Yulonda B. S	eals	Wife		140	8 Wat	erle	ess S			ettesvil	le,	N.C.	2830
Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 X Burial 2 Crematic 4 Donation 5 Other 3 21. Signature of Funeral Service	Specify:	noval from Sta	216	rematory or ot ndhills 22.1					14-06 arch F.	Sprin	g La	ake, N	.c.
Physician	-	23a. Part I. Enter the disease, of failure. List only one caus			the death.					Ave	., Balt	imore, M		Approximate Between C	te interval
/Medical Examiner		Immediate Cause (Final diseas or condition resulting in death)	e a. Hype Due to			cular Dise	ase						\dashv	Dea	
ed ssit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Caus (Disease or injury that initiated events resulting in death) Last	e c	(or as a conse											74
be execultion and urial - tra	edical	UNPENDED		NDED								Lood Bata of a	1-11		
ords, P.O. Box 6876(w requires that the death certificate is been signed by the attending physhould be detached for use as the b	Physician/M	IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 U		If yes, outcor Live birth Pregnant at Unknown		2 Fe	etal death ther (Spec	3 [ify)	Ectopic	pregnar	ncy	23d. Date of d Month	Da	ıy	Year
, P.O. I res that the signed by the detached	ğ	Part II. Other significant cond End stage renal disc		buting to deat	h but not re	sulting in the	underlying	cause gi	ven in Par	t I.		obacco use contrib			
of Vital Records, ig Physician: The law require there this certificate has been sineral director, page 2 should be	Completed						-				1 🗸 Yes	osy pr ormed? de		oppsy findings ompletion of	
_ = < 2	ition: To Be		Hospital 28	Inpatie a. Date of Inju (Month, Day,)	ıry T	ER/Outpatien 28b. Time of	t 3 🗌 D	DA C	of Death (Cother 4	Nursing	Home 5	Residence 6 v		Scene	
Division Bospital or Attendin 24 hours after death. Funeral Director: /	Certification:	3 Suicide 6 Co	ermined (Specify)		ome, farm, stre					or Town, S				mber, City
To the Hos within 24 ho To the Fun completely:	Medical	(Check only one) 2 Medical Ex	aminer: On the				ition, in my	opinion,	death occ			se(s) and manner and place, and du	ue to the	cause(s)	<u> </u>
	Σ	29b. Signature and title of certi	er H	all	oci		290	O.C.N	number /I.E.			29d. Date signe November 2		-)
5 ⁴			ssistant Me	edical Exa	miner	111 Penn	Street, E	Baltimo	ore, MD	21201			escini.		
Sta Regist	ate rar	31. Date filed (Month, Day, Yea,	8 2006	32. Rébistra	r's Signatu	15 A									

State Registrar 29b. Signature

31. Date filed (Month)

1219

2006

of person who completed cau e of death (Item 23a) (T. pe. Print)

gheva

32. Registrar's Signature

29c. License number

1-0054218

29d. Date signed (Month, Day, Year)

Malcaly dine west more MO 2/157

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of H			ene20(6 35321
	Physici /Medio		1. Decedent's Name (First, Middle, Las Bernicl	- A.	StoWr	nan		2. Date of Death Month	Day-Ma	(ear 000. 1.54 p M
	Examin	er	4a. Facility Name (If not institution, give	inty Ge			olun	oble		ward
	Funeral Director		5. Social Security Number 433-14-9294 Usual Residence of Decedent	M 2 AF	e (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		rearl	9. Birthplace (State or Foreign Country) Louisiana
	Maryland -f ehow	tor	10a. State 10b. County	rd Co.	10c. City, Town or Lo	Columbi	ia		-	10d. Inside City Limits 1 ☐ Yes 2X No
	h with the	al Director	10e. Street and Number 6007 Offshore G	reen		10f. Zip Code	21044	10	g. Citizen of Wh	nat Country? USA
036	within 72 hours after death with the Maryland ene. then "natural", or items 23a or 28e-f ehow the Medical Exercit er med the codified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ ☑ worced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes ※ No	spanic Origin? (n, Mexican, Pue Specify:	Specify Yes or No- into Rican, etc.)	Black,	American Indian, White, etc. White
21215-0036		Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 7th	ucation de <i>completed)</i> College (1-4or 5	(Give	dent's Usual Occupa kind of work done of DO NOT use retired Cashie	during most of w)	orking	Bakery	
Maryland	2 should be filed and Mental Hygi ie marked other aumatic event,	To Be C	17. Father's Name (First, Middle, Last) William Ansard	i				ame (First, Middle, Ma .ce Ansar		
	tra tra		19a. Informant's Name/Relationship ($T_{ m i}$ Merry L. Pomero		ter 263	8 Wooler		Bural Route Number, 6 Jacksonv		
Baltimore,	permit. Pages 1 an Depertment of Heal Important: If Item 2 eny injury or other once.		20a. Method of Disposition 1 Burial 2 Sermation 3 4 Donation 5 Other (Specify,		Metro C	matory or other plac rematory	11/	7/2006	atonsv	rille, MD
Balt	Depenti Depenti Import eny inj once.		21. Signature of Juneral Service Usens	augut	N 3	osi rali	<u>s koac</u>	Baltim	ore, M	ome, Inc. ID 21211
=	Physician		23a. Part 1. Enfer the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition	lications ha caused ne cause o each lin	Sent	in Pl	roch	_		Approximate Interval Between Onset and Death
	/Medical Examiner	<u>.</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	a consequence of):	te my	rai	dial my	aute	'n
8760,	cate be executed physicien and and the burial-transit	dicai Examine	Cause (Disease or injury	с	Auma consequence of):	te ren	al to	rulnee		
Box 6	Physician: The law requires that the death certific this certificete has been signed by the ettending praid director, page 2 should be detached for use as t	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy			23d. Date of Month	
rds, P	quires that en signed t uld be deta	ed by P	Part II. Other significant conditions co Often	ntributing to death.bu	ut not resulting in the u	nderlying cause give	n in Part I.	23e. Did toba	-1	ute to the cause of death?
Division of Vital Records, P.O.	: The law re cete hes bed page 2 sho	Completed	dement	la				24a. Was an autopsy performe	d? prio	re autopsy findings available or to completion of cause of th?
<u> </u>	sician certifi rector	Be	25. Was case referred to medical examiner?	Hospital:		Otho		ath (Check only one)	L.	
ion of	To the Hospital or Attending Physician: The law within 24 Hours after death. To the Funerel Director: Atten this certificate hes completely filled in by the funeral director, page 2.	ation: To	1 Yes 2 No ' 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 28a. Date of Injur (Month, Day		28c. Injury Work	at ? ′es 2 ∐ No	Home 5 Residence 28d. Describe how		(Specify)
Divis	tal or Atters after der	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc	rry - At home, farm, str (Specify)	eet, factory, office		28f. Location (Stree City or Town,	et and Number (State)	or Rural Route Number,
	To the Hospital or Ati within 24 hours after of To the Funeral Direct completely filled in by	Medical	one)	and manner sta	of my knowledge, death examination and/or in- ted.	vestigation, in my op	inion, death occ	urred at the time, date	and place, and	due to the cause(s)
)	with con	2	29b. Signature and little of certifier	- NO		29c. License	number 7	O 29d	Date signed (A	Month, Day, Year) 2006.
	X		29b. Signature and Jitle of certifier 30. Name and address of person who put 5005 S79 NAJ B 31. Date filed (Month, Day, Year)	ompleted cause of de	eath (Item 23a) (Type,	Print) Lille	MD.	21029/	Sur	an Abdo MD
	Sta Registr		NOV 0 8 20	06 A stra	r's Signature	348		1/0		

DHMH 17 Rev 1/2001

NOVEMBER ¢, *:20 p.m.

CHERLEIN SCHARPE	vision of Vital Records, P.O. Box 6876	r Attending Physician: The law requires that the death certificate bar death	ractor: After this certificate has been signed by the attending physic
5	sion o	Attending Pi	or: After th
	=======================================	Att	ract

		•	For State Registrar		State of	Marylan		artment of F <i>rtificate of</i> a			giene Reg. No.	2 U U b	35322
			Decedent's Name (F	First, Middle,	Last)	***	-			2. Date of De			3. Time of Death
	Physici /Media		Cherlein		Α		Scha	rpe		Novemb			8:20 P M
)	Examir		4a. Facility Name (If no	ot institution,	give street and num	ber)		4b. City, Town, o	r Location of Death		4c.	County of Deall	n
			Stella M					Timor				Baltime	
	Funeral Director		5. Social Security Num 220-07-570	2	5. Sex 7 1 □ M 2 🛣 F	Age (In yrs. I	Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Bir (Month, Da			nplace (State or Foreign untry) ryland
	death with the Maryland me 23a or 28a-f ahow rmust be notified at		Usual Residence of De 10a. State 10	Ob. County		10c. City	, Town or Lo	ocation					10d. Inside City Limits
	e Ma	cto	Maryland	Balti	more		Timo	nium	_				1 ☐ Yes 2 🛣 No
	il th	Dire	10e. Street and Number	er				10f. Zip Code			10g. Citi	zen of Whal Co	untry?
	ath w	E .	26 Culmo	re Cou				2109	-			USA	
9		Funeral Director	11. Marital Status 1 ☐ Never Married	2 Marrie	12. Was Deced Armed Ford 1 Tes 2 If Yes, Give	es? ? W No		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ▼ No	lispanic Origin? (S) an, Mexican, Puerti Specify:	pecify Yes or No Pican, etc.))-	 Race - Amer Black, White Specify: 	
8	72 hours after natural', or its	d by	3 Widowed 4 [Year or Dat	es:			Specify.				White
Maryland 21215-0036	"natu	Completed	15 (Specify	 Decedent's only highest 	s Education grade completed)		(Give	dent's Usual Occup	during most of wor	king	16b. Ki	nd of Business/I	ndustry
121	withir	mp	Elementary/Seconda	ary (0-12)	College (1-			DO NOT use retired	3)			O I	7
d 2	Hygin ther		12 17. Father's Name (Fin	st, Middle, L	n/a		п	omemaker	18. Mother's Nan	ne (First, Middle	Maiden	Own I	тоше
an	ld be ental kad c	To Be	Henry		Beck	mann			Barb	ara		Dehne	3
چ	2 should be and Mental is marked of	-	19a. Informant's Name	a/Relationshi		ARALILI	19b. Maili	ng Address (Street			er, City o		
	nd 2 aith a 27 is r trau		Linda M.	Corbet	t/Daughte	r	26	Culmore (Court. Ti	monium.	MD	21093	
ē,	s 1 and 2 of Health Item 27 I	1	20a. Method of Dispos	ition		20b. Pl	lace of Dispo	osition (Name of matory or other place		Date		cation - City or	Town, State
Ë	Page nent o nt: If ry or		1 (28 Burial 2 □ 0 4 □ Denstion 5 [3 □Removal from S ecify)	tate	-	alley Men	11/	10/06	Time	onium N	fary land
Baltimore,	permit. Pages Department of I Important: if Its any injury or o		21 Supply	ant) Clus			2. Name and Addre emmon Fundament of W. Pado		e of Du	laney	y Valley	Inc.
	7,00		23a. Part1 nter the	w. Cla	complications that ca	sed the death	Do not ent	U W. Pado	nia Koad	or respiratory a	rrest	MD 210	Approximate
1	Physician /Medical Examiner		Immediat Cause (Findisease of condition resulting in Health)	nal	a END S	ch line. TAGE DE r as a consequ	MENTL						Interval Between Onset and Death
	b d L ansit	Examiner	Sequentially list condit if any, leading to imme cause. Enter Underlyi Cause (Disease or inju-	ediate ing ury	Due to (o	r as a consequ	uence of):						
68760,	ficate be executed physicien and the burial-transit	edical Exa	that iniliated events resulting in death) Las	t	c	r as a consequ	uence of):						
		Med	IF FEMALE:										
P.O. Box	it the death certifi by the attending I lached for use as	Physician/M	23b. Was decedent pr in the past 12 mo 1 ☐ Yes 2 ☑N 9 ☐ Unknown	onths?		th 2 ☐ Fetat nt al time of de	death 3[Ectopic pregnancy Other (specify)	1		2	23d. Date of deli Month	very Day Year
ds, P	w requires that the strain of	þ	Part II. Other significa	nt condition	ns contributing to dea	ath but not resu	ulting in the u	nderlying cause giv	en in Part I.		obacco u Yes 2 (the cause of death?
S		etec								-			Total Contract Contra
i Rec	The la ete has page 2	Completed								24a. Was autor perfo		prior to death?	topsy findings available completion of cause of 2 No
/ita	Physician: Th this certificete al director, pag	Be	25. Was case referred examiner?	to medical					26. Place of Dea	th Check only o	ne)	-	
7	Physi this c	ို	1 ☐ Yes 2 No			patient 2 1			4 Nursing ri				ify) HOSPICE
NO.	fer fer	lon		5 Pending		, Day Year)	28b. Time o Injury	Wor		28d. Describe	how injur	y occurred	
Division of Vital Records,	or Attenditor death	Certification:	2 Accident 3 Suicide 4 Homicide	invesliga 6 🗌 Could no determin	ot be 28e. Place of	of Injury - Al ho g, etc. (Specify		M 1 []	Yes 2 □ No	28f. Location (: City or To	Street and	d Number or Ru)	ral Route Number,
۵	To the Hoepital or Attendi within 24 hours effer death. To tha Funeral Diractor: A completely filled in by the to	edical Cel	(Check only 2	Certifying Medical E	Physician: To the base	sis of examinat	wledge, deat tion and/or in	h occurred at the tin	ne, date and place	, and due to the	cause(s)	and manner as	stated.
	To the I within 2 To the I complet	Med	one) 29b. Signature and title		and manne	er stated.		29c. Licens	e number			e signed (Monti	i, Day, Year)
)	1			10	13725			11/7/0	6
	6		30. Name and address DR. TARIO	MATRICO	on 0000 i	of death (Item		Print)			13		
	Sta		31. Date filed (Month)	Pay Year)	2006 32.	gistrar's Signal	lur	Cocks	IMONIUM,	LIN 2103	<u>.</u>		
	Registi	ar		0 0	and the second	\$@\$\\\ J	No. 1						

Division or Vital Records, P.O. Box 68760.

State Registrar

31. Date filed (Month, Day, Year) NOV 0 8 2006 \$2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Suite 18 Baltimore, Md. 21229

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005 35324 1 - For State Registra Certificate of Death Reg. No. 2012/1, vobui 21:125 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Robert John Stritzinger November 2006 10:45 p ^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4 Marathon Ct. Apt 2D Catonsville Baltimore 5. Social Security Number 8. Date of Birth (Month, Day, Y Sept 10, 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) **Funeral** 1₽M 2□F Year, 218-46-5804 Director 58 1948 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits or 28a-f show the Medical Exertiner must be notified at MD Baltimore Catonsville Director 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4 Marathon Ct. Apt 2D "natural', or Iteme 23a 21228 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 XYes 2 No If Yes, Give 2-71 Year or Dates: 2-71 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White ģ 3 ☐ Widowed 4 ☒ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. em 27 le marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Manager Warehouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ralph Francis Stritzinger Inez Patrick Guthrie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 of Department of Health ar Important: If item 27 le any injury or other trauonce. Inez P. Stritzinger/Mother 2807 Baker Lane Bowie MD 20715 20b. Place of Disposition (Name of comptent), crematory or other place)
Mary Land Veteran Cem
at Crownsville 20a. Method of Disposition 20c. Location - City or Town, State I XBurial 2 ☐ Cremation 3 ☐ Removal from State Opnation 5 Other (Specify) 11-09-2006 Crownsville, Maryland Signature of Funeral Spryice Licens 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus MD 21227 23a. Parti. Enter the disease or complications that caused the death) Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of): physician a P.O. Box 68760. 23d. Date of delivery

Completed by Physician/Medical Be ٤ After this Certification: filled in by the

Records,

of Vital

Division

or Attending Physicien:

death.

within 24 hours after deal To the Funeral Director:

23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1XYes 2 No 3 Probably 4 Unknown 24a. Was an autopsy perform performed?
1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

1366

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No

eted cause of death (Item 23a) (Type, Print) MD 6 M:1: tello Trimble

Hill CT. Luthenville,

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

Medicai

State

Registrar

NOV 0 8 2006

2. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2006 35325 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month NOV. Day 5 **Physician** Diane Lynn Seyb 2006 1:20 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death Examiner 308 Orley Road Catonsville Baltimore If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 484-68-6723 1□M 2√FF 53 Yrs. Director 3/20/1953 Iowa Usual Residence of Decedent 10c. City. Town or Location 10d Inside City Limits 10a State 10h County in then "naturel", or iteme 23s or 28s-f show 1 ☐ Yes 🏖 No Donnellson Director **Towa** Lee 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S. 52625 3 Fairway Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: δ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other then College (1-4or 5+) Elementary/Secondary (0-12) Ft. Madison County Health Inspector 10th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental I ie marked Lola Hunter Dean Lorence 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important; If Item 27 te m eny Injury or other traum once. Kent Seyb 3 Fairway Court Donnellson, Iowa 52625 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Evangelical Cemetery 11/9/2006 4 ☐ Donation 5 ☐ Other (Specify) Donnellson, Iowa 22. Name and Address of Facility Sterling Ashton Schwab Witzke 21. Signature of Funeral Service License Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville MD 21228 Approximate Interval Between Onset and Death Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Hypentensiue Artonio sclonotic Candio vas cular Diseaso Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): certificate be executed as the burial-transit Exam that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months?
1 Yes 2 No Month Day 4☐Pregnant at time of death 5 Other (specify) ned by the a e detached for о. О. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. چ Records, sign. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been si 24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 20 No certificate 1 Yes of Vital Physician: 25. Was case referred to medical examiner?
1 X Yes 2 □ No 26. Place of Death (Check only one) Be dayanter s Other: ..endin. r death. 'tor: After th. 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) 2 Höme 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: Division 1 Natural 5 Pending To the Hospital or Attendir within 24 hours after death. To the Funeral Director: At completely filled in by the fu 1 ☐ Yes 2 ☐ No М investigation 2 Accident 6 Could not be determined 3 Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 | Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 1866 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H: 11 CT. Lutherville, MD M:1: tellOMD Trimble Le 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

		-	For State Registrar	State of Maryla		artment of H			2000	35327
			Decedent's Name (First, Middle, Last)			/	Jean	2. Date of Death		3. Time of Death
	sicia edic		Bertha		S	hocken		November	Day Year 2006	5 7:03 Р. м
	mine		4a. Facility Name (If not institution, give s				Location of Death		4c. County of De	
			220 Cresswell Ros 5. Social Security Number 6. Sex		s. last birthday)	Balti If Under 1 Year	more If Under 24 Hrs.	0 D-1- (B)	Anne A	
Fune Direc				м 2 X F 79	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,) July 23,	1927 Ma	rthplace (State or Foreign Country) ry land
D			Usual Residence of Decedent					July 20,	1727 110	
anylar		2	10a. State 10b. County Maryland Anne Aru		City, Town or Lo Baltimo					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
the M		Director	10e. Street and Number			10f. Zip Code		100	Citizen of Milhan C	
1215-0036 within 72 hours after deeth with the Maryland ene. then 'retural', or Hems 23e or 28e-f show		ā	220 Cresswell R	oad		212	25	100	g. Citizen of What C U.S.	ountry?
deeth		by Funeral	11. Marital Status	2. Was Decedent Ever in	U.S. 13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp	ecify Yes or No-	14. Race - Am	
atter or tte		Fu	1 Never Married 2 Marned	Amed Forces? 1 ☐ Yes 2 ♠ No If Yes, Give		rres,specnyCuba 1 □ Yes 22X No		Hican, etc.)	Black, Wh Specify: Wh	
21215-0036 d within 72 hours alt giene. or then 'naturel', or		q p	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:						
15 nin 72		plete	(Specify only highest grade	completed)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired	during most of work	ting 16	6b. Kind of Busines	s/Industry
212 d with giene		Completed	Elementary/Secondary (0-12) 12th	College (1-4or 5+)	Tele	phone Ope	erator	F	ort Meade	9
Maryland 2 d 2 should be filed th and Mental Hygi		Be	17. Father's Name (First, Middle, Last)	E. Bush				e (First, Middle, Ma	aiden Sumame) hea Quand	+
should Ind Men		ဥ			401 14 111					
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28e-f show		1	19a. Informant's Name/Relationship (Type Kenneth Shockey /			ng Address <i>(Street a</i> resswell			City or Town, State, Mary land	
re, N s 1 and f Health ltem 27		1	20a. Method of Disposition			sition (Name of matory or other place			c. Location - City o	
Pages	5		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	SHIOVAL HOLLI State		L1 Cemete	1	5/2006 Ba	altimore,	Maryland
Baltimore, permit. Pages 1 a Depertment of Hez Important: If Item	DDC#	Ì	21. Signature of Funeral Service License						ral Servi	ce. P.A.
00 865	ä		Jerome gra	musuul	W 41	OOl Ritch	ie Highwa	ay Balti	more, Mar	yland 21225
			23a. Rutt1. Enter the disease or complications, or heart failure. List only on	eations that caused the de e cause on each line	ath. Do not ent	1 -		or respiratory arres	t,	Approximate Interval Between Onset and Death
Physic /Medi			Immediate Cause (Final disease or condition resulting in death)	Longesti		eart fa	ilure			
Examir				Cardiow	,	4hm				
m là/a	-	ner	if any, leading to immediate cause. Enter Underlying	Due to (or as a cons	eq nce ():		- X			
cords, P.O. Box 68760, wrequires that the death certificate be executed to the second of the second	200	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Hyperten	vive !	Arterio:	sclerotic	: Cartior	ocularo:	joue
760, te be ex ysicien	8	calE		Du∋ t∜(or as a conse	equence or):					
687 flicate			0							
Vision of Vital Records, P.O. Box 68 Attending Physician: The law requires that the death certifics reasth. reach: Alter this certificate has been signed by the ettending precior. Alter this certificate is a physicial for the control of the cont	900	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	Bc. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe		Te			23d. Date of de	elivery
O. O. O. O. O. O. O. O. O. O. O. O. O. O	2	sicla	in the past 12 months? 1 ☐ Yes 2 ☑ No	4☐ Pregnant at time of		Ectopic pregnancy Other (specify)			Month	Day Year
P.C Dratthe dby tl	200	Phy	9 Unknown					00 Bitte		
dS, ires th		by	Part II. Other significant conditions con	routing to death but not re	esulting in the u	nderlying cause give	en in Part I.	1 ☐ Yes	No.	to the cause of death? Probably 4 □Unknown
v requ	000	ete	Charte al .t.	active Lu	· D:	40.50				
Re lay	200	E C	Chronic Dostar	ictive can	س ن	, Zw, Z		24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
Division of Vital Records, or Attending Physician: The law requires the alter death. Director Attention centificate has been signed.	2	4	25. Was case referred to medical				26 Place of Deat	1 ☐ Yes 2) h (Check only one)	No 1 □ Ye	s 2□No
ysici	5	To B	examiner? 1 ☐ Yes 2 No	ospital: 1 Inpatient 2	☐ ER/Outpatien	t 3□ DOA Othe			ce 6 □Other (Sp	ecify)
ng Pt	9	ü	27. Manner of Death 1 SNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injury Work	at	28d. Describe how		
ISIO Itendi Joath. Tor: A		catl	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		lis .		res 2 □No			
Divi	à	Certification;	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str cify)	eet, factory, office		281. Location (Stre City or Town,	et and Number or F State)	Rural Route Number,
spite nours			29a. Certifier 1X Certifying Phys	ician: To the best of my k	nowledge, death	occurred at the tim	e, date and place.	and due to the cau	se(s) and manner a	s stated
Division of Vital Rec To the Hospitel or Attending Physicien: The law within 24 hours atter death.		Medical	(Check only 2 Medical Examin one)	er: On the basis of examinand manner stated.	nation and/or in	vestigation, in my op	pinion, death occur	red at the time, date	e and place, and du	e to the cause(s)
To t To t	8	Σ	29b. Signature and title of certifier			29c. License		290	. Date signed (Mon	
7	/		" he vac				6203		11/05/	06
-	1		1 11 11 11	npleted cause of death (It		Print)	010	3.11:		0 21227
	Stai	e	31. Date filed (Month, Day, Year)	32. Registrar's Sig		warkalls	, 1-0, 1	valtim	are m	1) LILLY
Reg	gistra		NOV 0 8 200	200	No A	acles				
				Total Control	- A					

ORIGINAL

06-08035 Gregory Spencer Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene 2006 35328 1- For State Certificate of Death Reg No Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Time of Death Physician/ Month Day October 25, 2006 Medical Examiner Gregor pencer 1652 hrs 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death County of Death NIA 6918 Bank Street Baltimore 5 Social Security Number 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7 Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs **Funeral** Months Foreign Days Director 218.104.0276 1 XM 2 Country) MD Usual Residence of Decedent Any IOc. City, Town or Location 10d Inside City Limits Baltimore MD items 23a or 28a-f show ust be notified at once. 1 Xres 2 No hours after death with the Maryland Director 10e. Street and Number 10g Citizen of What Country? 21224 USA Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, Black, 12. Was Decedent Ever in U.S Armed Forces? White etc. 1 Never Married 2 X No Yes 0 Black Widowed f Yes. Give Year Yes 2 X No specify Specify: marked other than "natural", revent, the Medical Examiner ş 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done 16b Kind of Business/Industry Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 l Department of Health and Mental Hygiene Chemical Plant echnician th grade NIA 17. Father's Name (First, Middle, Last 18 Mother's Name (First, Middle, Maiden Surname) Be Inema Johnson 19a. Informant's Name/Relati nship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 is Silverbell Koad Baltimore MD 21224 helma 20b Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Date other Burial 2 Cremation 3 Department Important: 1 Battmore, MD Hill Cemeter Cedar 10/31 Donation 5 Other Specify 22, Name and Address of Fatigue Funeral Senices 4905 York Load Baltimpre MD 2/212 Mature of Funeral Service Lic 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure List only one cause on each line Between Onset and /Medical Death Acute bronchopneumonia Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): requires that the death certificate be executed and Physician/Medical attending physician at X AMENDED #1 X UNPENDED #23a.PII.27.perME. g862. 12/27/06 TT Division of Vital Records, P.O. Box 68760, IF FEMALE: 23d Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death Day Year past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Chronic alcohol abuse Yes 2 No 3 Probably 4 V Unknown Completed 24a Wasan 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? ✓ Yes 2 1 V Yes Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be Other₄ Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene 1 V Yes After 1 27. Manner of Death 28a Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred Certification: 1 X Natural thours after death 1 Yes 2 No Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined 4 Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical within 2 To the 1 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ,0 and manner stated 29b Signature and title of certifie 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E. October 26, 2006 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32 Registrar's Signature State NOV 0 8 200 Registra

			for State	State of Maryland				Mental Hygi		25220
			Registrar 1. Decedent's Name (First, Middle, I	(ast)	Cei	rtificate of I	Death	Reg	3. NG UUD	35329 3. Time of Death
1	Physici		MARY	SZRO	4.4			Month NOV EM	Day Year	D 11
Y	/Medic Examin		4a. Facility Name (If not institution, g		IN /	4b. City, Town, or	Location of Dea		4c. County of De	
			6627 Hudson S			Balti			n/	a
	Funeral Director		5. Social Security Number 219 – 32 – 2875	. Sex 7. Age (In yrs. & 1 ☐ M 2 ☐ F 96	a <i>st birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	Month, Day,	rear) C	irthplace (State or Foreign Country)
		1	Usual Residence of Decedent				<u> </u>	Mar7,19	110 Pe	nnsylvania
	arylan show	_	10a. State 10b. County		, Town or Lo					10d. Inside City Limits
	the Market Parket	ecto	Md. n/	а ва	ltimo	-			025	1½ Yes 2 No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturei", or Items 23e or 28e-f show any injury or other treumatic event, tre Madical Examinar must be notified at once.	Funeral Director	6627 Hudson S	treet		10f. Zip Code 2122	24	100	g. Citizen of What C USA	,
	ems 2	nera	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	3. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S	Specify Yes or No-	14. Race - Am	
36	or ite	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give X		1 □ Yes 2 □ No	Specify:	to riloan, dio.)	Black, Wh	hite
21215-0036	Phour sture!	ed b	15. Decedent's	Year or Dates:	16a. Dece	dent's Usual Occup	ation	16	Sb. Kind of Busines	
215	within 72 lene. than "ne	Completed	(Specify only highest of Elementary/Secondary (0-12)		(Give	kind of work done of DO NOT use retired	during most of wo I)	rking		
2	filed wil Hygien other th		Zna		Line	e Worker				& Blackwell
anc	ould be fi Mental H arked ot atic ever	Be	17. Father's Name (First, Middle, La	wilk				me (First, Middle, Ma	aiden Sumame)	
Maryland	should nd Men marke umatic	٦	19a. Informant's Name/Relationship		19b. Mailir	ng Address (Street a	Blanc		City or Town, State,	Zip Code) 2 1 2 2 4
	1 and 2 Health a Sem 27 is		John Szrom (g	randson)		7 Hudsor			more, M	
altimore,	Pages 1 and the neut of He neut of He neut; If item iry or oth		20a. Method of Disposition 1 ØBurial 2 ☐ Cremation 3		ace of Dispo emetery, crer	sition (Name of natory or other place	εθ)	Date 20	c. Location - City o	r Town, State
ţ	t. Pag rtment rtent: njury		`4 □ Donation 5 □ Other (Spec	cify) Sac	red He	art of Ma	ary Nov.	6,2006 Ba	altimore,	Maryland
Ba	permit. Departr Importe any inj		21. Signature of Funeral Service Lic) A A O						al Home, PA yland21222
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	implications that coused the death						Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	a DEBILLTY						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):					1 (0),
		e.	Sequentially list conditions, if any, leading to immediate	b. STROKE Due to (or as a consequ	ence of):					10 YEARS
	cuted d ansit	Examiner	cause. Enter Underlying Cause Unisease or injury that initiated events	HYPERTEN'	SION					
, 0	icate be executed physicien and s the burial-transit	Ex	resulting in death) Last	Due to (or as a consequ	ence of):					
8760,	icate b physic the b	Physician/Medical		d			· · · · · · · · · · · · · · · · · · ·			
Box 6	death certific e attending pl d for use as t	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar					23d. Date of de	elivery
	0 0	sicia	in the past 12 menths? 1 ☐ Yes 2 ☐ No	1□Live birth 2□Fetal 4□Pregnant at time of de 9□Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
P.O.	The law requires that the de ite has been signed by the a bage 2 should be detached	Phy	9 ☐ Unknown Part II. Other significant conditions		Iting is the	adarbira as us di	en in Death	220 Did toho		to the cause of death?
ds,	signe	d by	Tarm. Other signmeant conditions	Contributing to death but not less	iting in the di	idenying cause give	en in ranti.	1 □ Yes	/	Probably 4 Unknown
COL	law requir as been si 2 should	lete						24a. Was an	24b. Were a	utopsy findings available
Vital Records,		Completed						autopsy performe	prior to death? No 1 □ Ye	
/ita	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Linear				ath (Check only one)		
o	Phys this al diu	7	1 ☐ Yes 2 ☑ No 27. Manner of Death		PVOutpatien 28b. Time of		4 🗀 Nullaling i	lome 5 Resident		ecify)
ion	Attending r death. ector: After by the fune	ation	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigat	(Month, Day Year)	Injury	Work	k? Yes 2 □ No	200. 2000/120 110/	injury occurred	
Division	I or Attendi efter death. Director: A I in by the fu	Certification:	3 Suicide 6 Could not determine		me, farm, str	eet, factory, office		28f. Location (Stre City or Town,	et and Number or R State)	iural Route Number,
Ω	pitel or urs efte erei Dire		00 0 17							
	To the Hospitel or Attending I within 24 hours effer death. To the Funerel Director: After completely filled in by the funer	edical	29a. Certifier 1 Certifying I (Check only 2 Medical Ex	Physicien: To the best of my know aminer: On the basis of examinati and manner stated.	vledge, death ion and/or inv	occurred at the time vestigation, in my op-	ne, date and place pinion, death occ	e, and due to the cau urred at the time, date	se(s) and manner a and place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	. / /		29c. License	number	290	I. Date signed (Mon	th. Day, Year)
)			James	Hundle	MD	06:	2032	N	OVEMBER	3 2006
	6		30. Name and address of berson who venniter Hayashi, M		23a) (Type,	Print)	BALRINI	PEMN 91	724	
	Sta	te	31. Date filed (Month, Day, Year)	32. Regionar's Signati	ure		O'CCI MU			
	Registr		NOV 0 8	3 2006 June	K A	Coste				
DH	MH 17 Rev 1/2	201		Q ⁿ						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 4a per doc 9861 11-8-06 vt. State of Maryland / Bepartment of Health and Mental Hygiene Certificate of Death Reg. Ng. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year **Physician** 7:00 PM 2006 YOU Helen Elizabeth Spicer /Medical street and number) 4c. County of Death 4a. Facility Name #10 institution, o 4b. City, Town, or Location of Death **Examiner** MINERSLI LOREIA CAM If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☐ M 2X F Yrs. Director 83 216-16-2648 Jul. 17, 1923 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 □ No Funeral Director Maryland Harford
10e. Street and Number Bel Air 10f. Zip Code 10g. Citizen of What Country? 104 Dublin Ct. 21014 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: δ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Procurement Supervisor U. S. Government permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Importent: If item 27 Is marked other th any Injury or other treumstic event, Im-onca. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herbert Howard Hopkins Cora Estelle Day 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nter 708 Orley Place, Bel Air, Maryland 21014

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date 2°c. Location · City or Town, State Stephanie Flannery/Granddaughter Baltimore, 1 ⊠Buriay 2 ☐ Cremation 3 ☐ Removal from State tion 5 Q ner (Specify) Bel Air Memorial 11-4-06 4 Dong Bel Air, Maryland 21. Signature of Funera 22. Name and Address of Facility McComas Funeral Home, P. A. 1317 Cokesbury Rd., Abingdon, Maryland 21009 23a Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death) **Physician** (or as a consequence of) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and the burial-transil Due to (or as a consequence of): Box 68760 Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 | Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 3 Jas certificate ha 1 Yes 2 1 No Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Cther: Ursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 ER/Outpatient 3 DOA Certification: To 2. No this 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred fnjury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: / 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

To the Funerel C

completely filled i 29a. Certifier 😭 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) MP who completed cause of death (Item 23a) (Type, Print) thi Mamie gistrar's Signature 32. State

DHMH 17 Rev 1/2001

Registrar

M

2006

		1 - For State Registrar	State of Marylan		artment of H			ene 2.006	35331
	dical	Decedent's Name (First, Middle, Last) Frederick Clark Aa. Facility Name (If not institution, give st			4b City Tourn o	Location of Death	2. Date of Death Month November	Day Year	3. Time of Death 10:30 A M
Exar	niner	1505 Holman Drive		(Edgewood If Under 1 Year	xd		Harford	
Funer Directo			7. Age (In yrs. 76	V	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept. 9,	Year) 9. Birtl Co	nplace (State or Foreign untry) ginia
death with the Maryland me 23a or 28e-f ehow	Director	10a. State 10b. County Maryland Harford		y, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 XNo
with th	I Dire	10e. Street and Number 1505 Holman Drive	2		10f. Zip Code 21040		10	g. Citizen of What Co USA	untry?
je 2 2	by Funeral		2. Was Decedent Ever in U. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates:	1	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- Pican, etc.)	14. Race - Ame Black, White Specify:	
within 72 hours at ene. then "natural; or he would be at a factor of the matural of the world be at a m	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)		(Give	lent's Usual Occupa kind of work done of DO NOT use retired	furing most of work	king	6b. Kind of Business/l	
A 5 6 5 1	Con	6 17. Father's Name (First, Middle, Last)		Carre	nter	18. Mother's Nam	e (First, Middle, M	Construction Surgame)	on
	To Be	James Edmonson	Smith			Annie M			
2 sh and is rr		19a. Informant's Name/Relationship (Type Yvonne C. Smith / V						City or Town, State, Z	
ore, not health	1	20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of natory or other place			Maryland 2 Oc. Location - City or	
Pa Pa ant:		Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	Bel	Air M	emorial (erdn. 11-		el Air, Mai	ryland
Deart Depart Import	9000	21. Signatur of Funeral Service Licenses	R-	M	Name and Address Fu	ineral Ho	me, P.A.	don, Marvl	7 21000
Medic. Examino Thysicien and The burial-transit	lcal Examiner	23a. Par11. Enter the disease, or comples shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, it also be a condition cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a consequence of the consequence)	uedce of):	er the mode of dyin	g, such as cardiac	or respiratory arre	st.	Approximate Interval Between Onset and Death
the death certificate the attending physiched for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of deli	very Day Year
w requires that the debeen signed by the a should be detached to	ρ	Part II. Other significant conditions cont	ributing to death but not resu	ulting in the ur	nderlying cause give	en in Part I.		acco use contribute to	the cause of death?
The law ate has to page 2 s	Completed						24a. Was an autopsy perform	prior to c gd? death?	copsy findings available ompletion of cause of
Of VICAL Physicien: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	spital:	5D/0 · ·	Othe		h Check only one		
	늗	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injury Work	at	28d. Describe how	nce 6 Other (Spec vinjury occurred	ify)
UIVISION To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Afte completely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, str	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
the Hospi in 24 hou the Funer	edical	one)	cien: To the best of my line er: On the basis of examinat and manner stated.	wladge, death tion and/or inv	restigation, in my op	date and place pinion, death occur	and due to the cau red at the time, dat	tea(e) and manner as te and place, and due	olated. to the cause(s)
Viith To I	Σ	29b. Signature and title of certifier			29c. License			d. Date signed (Month	
1.11		30. Name and address of person who com	pleted cause of death (Item	23а) (Туре,	Dei-et)	22%		Divenber	(500C
GT I	2424	31. Date filed (Month, Day, Year)	32. Registrar's Signa	w. m.	ac Phase	/ R.	10,100	7	
Selection of the select	State istrar	NOV 0 8 20	06	N A	pedi				

		4	For State Registrar	State of Maryland / D	epartment of Healtl Certificate of Dea	th	Reg. No.	
I	Physicia /Medic		1. Decedent's Name (First, Middle, Last)	L	Sykes	2. Date of De Month	Day Year	3. Time of Death A
	Examin	er	4a. Facility Name (If not institution, give s 1. Social Security Number 6. Sex	atreet and number) ONAL 7. Age (In yrs. last birt.		e der 24 Hrs. 8. Date of Bir	4c. County of Deat	hplace (State or Foreign
	Director		216 54 5150	IM 2 Ø F 57	rs. Months Days Hou	rs Min. (Month, Da JUNE 2		YLAND
	Aaryland I ehow	ō	10a. State 10b. County	10c. City, Town				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	or 28a-	Director	MD . N/A 10e. Street and Number		PIMORE 10f. Zip Code		10g. Citizen of What Co	ountry?
	na 23a	Funeral	4203 ARIZONA 11. Marital Status	AVE . 12. Was Decedent Ever in U.S.	21206	Origin? (Specify Yes or No	usa - 14. Race - Ame	
5-0036	hours after death with the Maryland turel, or Itama 23a or 28a-f ehow al Examirativative publised at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:	If Yes, specify Cuban, Mex 1 ☐ Yes 2 ☑ Mo Spec		Black, Whit	BLACK
က်	within 72 ne. hen "ne e Medic	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during rife. DO NOT use retired)	most of working	16b. Kind of Business	Industry
Maryland 2121	outd be filed v Mental Hygie varked other t	Be C	17. Father's Name (First, Middle, Last)	2 yrs d		other's Name (First, Middle	, Maiden Sumame)	
ıryla	2 should the and Meni is marked aumatic	ှင	OLIVER TURNIPS 19a. Informant's Name/Relationship (Ty		Mailing Address (Street and Nu	CARRIE VA		Zip Code)
	1 and 2 : Health ar em 27 is other trau		DEBORAH C. VAUG		1618 WENTWO	RTH AVE. BA	ALTIMORE, M.	
more	Pages 1 nent of H int: if itee iry or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State cemeter	Disposition (Name of y, crematory or other place) AND CEMETERY	NOV.14,20		
Baltimore,	permit. Page Department of Important: If eny injury or gnce.		2) Senature of Funeral Service Licens	- H	22. Name and Address of F. CALVIN B. SC	acility	ERAL HOME	1213
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the death. Do not cause on each line.				Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence	08)S			y years
	Examiner	ler	Sequentially list conditions, if any, leading to immediate	Due to for as a consequence	л):			
8760,	licate be executed physicien and s the burial-transit	dical Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	of):			
.O. Box 68	requires that the death certificate be executed seen signed by the attending physicien and hould be detached for use as the burial-transit	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 PNo 9 □ Unknown	23c. If yes, outcome of pregnancy 1	3 Ectopic pregnancy 5 Other (specify)		23d. Date of de Month	livery Day Year
<u>α</u>	juires that the signed by ald be detacted		Part II. Other significant conditions co	ntributing to death but not resulting in	the underlying cause given in P		tobacco use contribute to	the cause of death?
Records,	e law hes b	Completed				24a. Wa. auto peri 1 □ Yes		utopsy findings available completion of cause of
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	Other	Place of Death (Check only		
of	Attending Physic death actor: After this by the funeral di	tion; To	1 Yes 2 Golo 27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	28a. Date of Injury 28b.	trainer of DOA 28c. Injury at Work? M 1 Yes		how injury occurred	(City)
Division	P # F	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury · At home, fa building, etc. (Specify)	rm, street, factory, office		(Street and Number or Rown, State)	ural Route Number,
	Hospitai 24 hours a Funerai I stely filled	ledicai		rsicien: To the best of my knowledge iner: On the basis of examination an and manner stated.				
	To the within 2 To the complet	Me	29b. Signature and title of certifier	1 . 1	29c. License num	ber	29d. Date signed (Mon	. 3
,	U		30. Name and address of person who	ompleted cause of death (liem 23a)	(Type, Print)	74	NWEMPO	16,2006 Have
1	IJ.		K.A. Kerridy	and Mercy	Medical Cew	ler Bal	timero, w	D 2/202
4	St: Regist	ate rar	31. Date filed (Month, Day, Year) NOV 0 8 2	32. Registrar's Signature 9	Signal Control		,	

:45

2006

NOVEMBER

SCHRIEFER,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 7.8 per fh c861 11-8-06 vt. State of Maryland / Department of Health and Mental Hygiene Reg. NZ U U 6 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 5, 2006 Physician Florence Sarage 11:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dulaney-Towson Healthcare Center Baltimore Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1929 (Month, Day, Year) Jan. 24, 1927 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign **Funeral** Days Hours Mary land 1 ☐ M 2 🕮 F 77 -79 Yrs. 217-20-4533 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location or 28a-f ahow 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylar ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Itams 23a or 28a-f ahow ury or other traumatic event, It a Mayled Examination as the multiple and Bultimore 1 Yes 2 No Maryland Funerai Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Ocola Avenue 2302 21215 United States 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married ∏Yes 2 Mo fYes, Give Year or Dates: Black 1 ☐ Yes 2 ☑ No Specify: Specifyþ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Bowling Alley Elementary/Secondary (0-12) College (1-4or 5+) oncession 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Brown Elsie Diggs Eliza 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Leona Savage-Daughter Baltimore, MD. 21215 2302 Ocola Avenue 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Nov. Date 10 1 Surial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Lansdowne, Maryland permit. Page Department of Important: If any injury or once. 2006 Mount Zion Cemetery 21. Signature of Funeral Service Licensee Calvin L. Wifiams Funeral Service, P.A. alvin P.O. Box 11651 Baltimore, Muriland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) cardio vasurlan disease Physician Attero sclentic 10 YVA /Medical Due to (or as a consequence of) **Examiner** perpheral Vasular disease YV Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attanding Physician: The law requires that the death certificata be executed burial-transit Due to (or as a consequence of) Physician/Medical as the l IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) detachad 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autopsy performed? 1 Yes 2 No funaral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

State

Wier-O Kion

NOV 0 8 2006

Km 206

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760,

P.0

of Vital Records,

mo

Gutar street

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N.

821

031865

md

Bastimore

11/6/06

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

	1- For State Registrar		Ce	ertificate of			F	leg No.	200	5 3	5335
Physician Medical Examine		(First, Middle,Last) $Austin T$	yson				2. Date of Dea Month Novembe		Year 6	3 Time of 1105	Death hrs
particular.		not institution, give streuse Point (Slip L			4b. City, Town, o	r Location of Death			County of Death		
Funeral Director	5. Social Security Nu 214 – 38 –	mber 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Ye	ar If Under 24Hrs		nth (MM/DE	[Casaia	hplace (Stan n untry)	ate or MD
any	Usual Residence of I	Decedent 0b. County	10c. Cit	y, Town or Locati	ion		- · • · · · · · · · · · · · · · · · · ·		<u> </u>	10d. Insid	e City Limits
<u> </u>	MD		Ва	altimon		7		_			s 2 No
the Maryland is or 28a-f sho otified at once.	10e. Street and Number 1211 S	Charles	St.		10f. Zip Code	21230		10g. Citizei	n of What Cour USA	try?	
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygene. unt: If item 27 is marked other than "natural", or items 23a or 28a-f show or other tranmatic event, the Medical Examiner must be notified at once.		d 2 Married ,	. Was Decedent Ever in Carmed Forces? X Yes 2 No. No. S. Give Year	If Y		ispanic Origin? (Sin, Mexican, Puerto			4. Race - Americ White, etc. Decify: Whi		Black,
y, MD 21215-0036 and 2 should be filed within 72 hours after leath and Mental Hygiene. ten 27 is marked other than "natural", traumatic event, the Medical Examiner. TO Re Completed by	15. Decedent's Edu		ghest grade completed) College (1-4 or 5+)	16a. Deceden	t's Usual Occupa ost of working life	ation (Give kind of e. DO NOT use ret	work done ired)	16b. Kin	d of Business/Ir	ndustry	
036 rithin 72 rne. rr than '	12		College (1-4 of 5+)	Tru	ıck Dri	ver			Ref	use	
21215-0036 Suld be filed within 7 Mental Hygiene. marked other than it event, the Medica		rst, Middle, Last) A. Tyson	Sr.			18.Mother's Name	e (First, Middle, Lan Jac		ırname)		
D 2121 should be f and Mental 7 is markec natic event,	19a. Informant's Nam	ne/Relationship (Type,				et and Number or	Rural Route Nu	mber, City			
ore, MD s.1 and 2 sho of Health and If item 27 is ner traumati	20a. Method of Dispo		20b	Place of Dispos	ition (Name of ce	arles St	Date		re MD		
Baltimore, ME permit Pages I and 2 s Department of Health as Important: If item 27 injury or other traums	4 Donation 5	Other Specify: eral Service Licensee	Removal from State Che	crematory or oth esapeal 22. N	ke Crem	natory 1	11/8/06 AFA	5 Be	eltsvi	lle,	MD
m	23a. rt I. Enter the	disease, or complicati	ons that caused the deat	გ წ71	l7 Gree	en Pasti	ires Di				2128 5
/Medical 		one cause on each li inal disease a Dro				,, , , , , , , , , , , , , , , , , , , ,				Betweer	Onset and Death
·	Sequentially list cond if any, leading to imm	nediate Due	to (or as a consequence	of):							
ted nisit	cause. Enter Underl (Disease or injury that events resulting in de	at initiated C	to (or as a consequence	of):							
		d	MENDED				· · · ·				
760, icate be executs physician amuthe burial - tru/Medical		regnant in the	3c. If yes, outcome of pre						Date of delivery		
Box 687 e death certific the attending ged for use as to	past 12 months?	4		de ath	tal death 3 her (Specify)	Ectopic pregna	ancy	M	onth D	ay	Year
ords, P.O. Bo w requires that the des sbeen signed by the should be detached it		cant conditions con	tributing to death but not	resulting in the u	inderlying cause	given in Part I.	23e. Did t		e contribute to t		of death?
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the ras after death "al Director: After this certificate has been signed by lled in by the funeral director, page 2 should be detach but Dertification: To Re Commissed by Dertification:			-				24a. Was	an	24b Were aut	opsy findin	igs available
Records, The law require freate has been signage 2 should be			<u></u>			-	auto perfo 1 ✓ Yes	rmed?	prior to co death? 1 ✔ Yes		of cause of
Vital Recysician: The list certificate lifector, page	25. Was case referre examiner?	d to medical Hosp	tal:	7	,	of Death (Check					
of Vil	1 Yes 2	No	28a Date of Injury	ER/Outpatient 28b. Time of I		ury at Work?	ng Home 5	how injury	e 6 🗸 Other	Scene	
IVISION or Attendin after death Director: A lin by the fu	1 Natural 2 Accident	5 Pending Investigation	Nov 5, 2006	1100 hrs		Yes 2 V No	Subject dro				
Division o spital or Attending sours after death neral Director: After filled in by the fune	3 Suicide 4 Homicide	6 Could not be determined	28e Place of Injury - At (Specify) Harbor	home, farm, stree	et, factory, office	building, etc.	or Town.	State)	Number or Rur (Slip L-18), E		
Division of Vital Records, P.O. Box 68' To the Hospital or Attending Physician: The law requires that the death certification of the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as labelical Certification: To Re Completed by Division	29a. Certifier (Check only one) 2 V	Medical Examiner: On	To the best of my knowle the basis of examination I manner stated				d due to the cau	se(s) and r	manner as starte	ed.	
	29b. Signaturie and ti		M		29c. Licen	se number .M.E.		1	te signed <i>(Mon</i>	-	ar)
5×1	30. Name and address		pleted cause of death (Ite	<i>'</i>	n Street, Bal	timore, MD 21	1201	1			V.
Stat Registra		Day, Year) 0V 0 8 2006	40		ASS.						
Registra	- '''		Season Control of the same	- July	-						

		1	_ State	ate of Maryland		rtment of He tificate of D			iene eg. No. 🤈 (200	25226
			1. Decedent's Name (First, Middle, Last)	Processor and all the re-			- Cutin	2. Date of Dea	th	100	3. Time of Death
	Physicia /Medic		INEZ BREHM	TREADWELL				November	6, 20	06	2:45P M
A.	Examin		4a. Facility Name (If not institution, give stree	t and number)		4b. City, Town, or		ath		y of Death	
,, 			Gilchrist Center		think to A	Towson	If Under 24 H	re O Data of Birth		ltimo	
	Funeral Director		5. Social Security Number 219-18-2239 6. Sex	7. Age (In yrs. I	Yrs.	Months Days	Hours Mi		10,1924	Mary	place (State or Foreign atry) Land
	pu ,		Usual Residence of Decedent 10a, State 10b. County	10c Cib	, Town or Lo	eation				1	0d. Inside City Limits
	faryla f shov ed at	ō									1 □Yes 2 No.
	the N 28a-1 notifi	rect	Maryland Baltimore 10e. Street and Number	! Dd	ltimor	10f. Zip Code			0g. Citizen of	What Coun	
	h with	a D	6901 B Lachlan Circl	.e		21239			USA		
	ems 2	Funeral Director	112 V	Was Decedent Ever in U	S. 13. V	Vas Decedent of His f Yes, specify Cuba	spanic Origin? n, Mexican, Pu	(Specify Yes or No- lerto Rican, etc.)		ack, White,	
36	s after ; or it	by Fu	1 ☐ Never Married 2 ☐ Married 1 3 ☐ Widowed 4 ※ ivorced	Armed Forces? Yes XX No f Yes, Give fear or Dates:	1	□Yes 🏋 No	Specify:		Speci	ity: W	Mhite
2-0036	e filed within 72 hours after death with the Maryland al Hygiene. althygiene. Applet than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	ed b	15. Decedent's Educatio	n	16a. Deced	lent's Usual Occupa	ation		16b. Kind of E	3usiness/Inc	dustry
215	hin 72 9. an "na Medio	Completed	(Specify only highest grade cor	mpleted) College (1-4or 5+)		kind of work done d OO NOT use retired,	furing most of v)	working	11.3.4.		
21	filed wit Hygiene ther the	Com	12		Roo	kkeeper	40 14-4-3-1	Inna (Final Middle		ng Co	mpany
Maryland 2121	s 1 and 2 should be filed f Health and Mental Hyg Item 27 is marked othe other traumatic event,	Be	17. Father's Name (First, Middle, Last) John H. Brehm					_{lame (First, Middle,} e Anna Loc		me)	
E Z	should be and Mental s marked o	ပ္	19a. Informant's Name/Relationship (Type. I	Print)	19b. Mailin	g Address (Street a	and Number or	Rural Route Numbe	r, City or Towi	n, State, Zip	Code)
	and 2 sealth ar n 27 is		Randolph E Wynn	Son				herville,			
ore	0 0		20a. Method of Disposition 1 ☐ Burial XXCremation 3 ☐ Remo			sition (Name of natory or other plac		Date	20c. Location		
	t. Pag tment tant; tjury o		4 □ Donation 5 □ Other (Specify)	Gre		int Cremat	• ,	/8/06 itchell-W		-	laryland
Ba	permit. Pag Department Important: i any injury o once.		21. Signature of Funeral Service Licensee	Kenaki	8	6500	York R	oad Balti	nore, M		
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one care	ons that caused the death	h. Do not ent	er the mode of dyin	g, such as card	diac or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	LUNG CA	mar					٧	months
	Examiner			Due to (or as) conseq	uence of):						
	100	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events c	Due to (or as a conseq	uence of):					- 7	
	cuted nd transit	Examiner	Cause Unsease or injury that initiated events resulting in death) Last								
90,	icate be executed physician and s the burial-transit	Ä	resulting in death) Last	Due to (or as a conseq	uence of):						
38760,		dical	d								
Box (nding use as	n/Me		If yes, outcome pf pregna		75-4			23d. D	ate of delive	ery
Ö.	uires that the death certificitions signed by the attending doe detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☑No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown		Ectopic pregnancy Other (specify)			N	Month .	Day Year
P.O.	hat the d by tl letach		9 ☐ Unknow/i * Part II. Other significant conditions contrib	uting to death but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use co	ntribute to t	the cause of death?
or Vital Records,	The law requires that the death certifite has been signed by the attending tage 2 should be detached for use as	d by						_ 101	es 2 No	3 ☐ Prot	bably 4 Unknown
000	aw requir s been si 2 should I	Completed						24a. Was	an 24t). Were auto	opsy findings available ompletion of cause of
Ä		Com						perfo	rmed? 2011No	death?	2 □ No
/ita	Physician: Th this certificate al director, pag	Be (25. Was case referred to medical examiner?	nital:		oth all DOA Oth		Death (Check only o			1
or/	S S :=	은	I Tes 2L	nai. 1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatier 28b. Time o	IL SELDON	4 🗀 Nursin	g Home 5 ☐ Resid			(1) Mospice
on	ding Phy h. After thi funeral o	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Wor	k? Yes 2∐No		,,		
Division	or Attending ter death. irector: After n by the fune	Certification:	2 LI Accident	28e. Place of injury - At h building, etc. (Special	ome, farm, sti fy)	reet, factory, office	-	28f. Location (\$ City or Tox		nber or Rura	al Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier Certifying Physicia	an: To the best of my kno	owledge, deat	h occurred at the tir	me, date and p	lace, and due to the occurred at the time.	cause(s) and date and plac	manner as s	stated. to the cause(s)
	To the H within 24 To the Fi complete	Medical	one)	and manner stated.		29c. Licens			29d. Date sig	ned (Month.	Day, Year)
	5 <u>**</u> 5 <u>**</u> 5	-	29b. Signature and title of certifier	~~		DS	8303		Noven	15er (0 2000
	91		30. Name and address of person who comp	leted cause of death (Itel	m 23a) (Type.	Print)					1204
	0		AARON Charles	m 6565	N.	Char	hs Sr	mm	ne "	no 21	1504
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	and s					

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** VIRGINIA 9:08 am STEWART TISCHA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Franklin Square
5. Social Security Number Hospital Center HOSedale
If Under 1 Year If Under 24 Hrs. Himore 8. Date of Birth (Month, Day, Year) 04-13-1932 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🕅 F Days Hours 74 216 28 2129 Director MD Usuat Residence of Decedent wode 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "natural", or items 23a or 28a-f shov other treumatic event, the Medical Examinar must be notified at Director MD BALTIMORE RASPEBURG 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 508 ELMWOOD RD 21206 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be Heelth and Mental STEWART CAVE CATHERINE HOWARD 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Heelth at In-portant: If Item 27 ie any injury or other treuging. JOSEPH TISCHA/HUSBAND 508 ELMWOOD RD RASPEBURG, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State GARDENS OF FAITH 4 □ Donation 5 □ Other (Specify) 11-10-06 BALTIMORE, MD 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee 1211 CHESACO AVE., ROSEDALE, Approximate Interval Between Onset and Death Shours 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Shock ardiogenic hours /Medical Due to (or as a consequence of): Examiner monary huper tension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): requires that the death certificate be executed attending physician end for use as the burial-transit OPD that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown Month 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Right middle lobe 1 ☐ Yes 2 ☐ No 3 Probably 4. Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No resection. 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Man er of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending hours after death. Inerei Director: Af y filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerei C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) Selinger 9000 Franklin Square 31. Date filed (Month, Day Year) State NOV 0 8 2006 Registrar

			1 - For State Registrar	State of Maryland	Department of He	ealth and Mental H	_
	Physici /Medio Examir	cal	1. Decedent's Name (First, Middle, La Lucille Tha 4a. Facility Name (If not institution, giv Kenesi's Porrin	me s	4b. City, Town, or		Day Year
	Funeral Director	/	5. Social Security Number 250-40-0308 Usual Residence of Decedent	Sex Age (In vrs. last	Yrs, Months Days	If Under 24 Hrs. 8. Date of E	9-18 S. Carolina
	n the Marylar r 28a-f show	irector	10a. State 10b. County 10c. Street and Number,	Ba	own or Location 14 inore 10f. Zip Code		10d. Inside City Limits 1 □ es 2 □ No 10g. Citizen of What Country?
	pernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Itams 23a or 28a-f show any nighty or other traumetic event, the Medical Exertinest by rudified at once.	Funeral Director	3008 HoRH	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of His If Yes, specify Cuban	spanic Origin? (Specify Yes or N., Mexican, Puerto Rican, etc.)	No- 14. Race - American Indian, Black, White, etc.
215-0036	"natural", or	þ	Widowed 4 Divorced 15. Decedent's E (Specify only highest gra	1 ☐ Yes 2 No If Yes, Give Year or Dates: ducation de completed)	1 Yes No 6a. Decedent's Usual Occupa (Give kind of work done de	Specify: tion uring most of working	Specify: Black 16b. Kind of Business/Industry
21	be filed within tal Hygiene. d other than " event, the Med	Be Completed	Elementary Segordary (0-12) 17. Father's Name (First, Middle, Last	College (1-4or 5+)	Homema	18. Mother's Name (First, Midd	Domestic Maiden Sumame)
Maryland	id 2 should be Ith and Mental 27 is markad c 1 traumetic eve	Tol	AOTON MC 10- Informant's Name/Relationship (Re-Hullhome	Type, Print) (Drughter)	9b. Mailing Address (Street at	nd Number or Rural Route Num	tack ber, City or Town, State, Zip Code)
Baltimore,	Pages 1 and 3 ment of Health ant: If item 27 jury or other tr		20a. Method of Disposition ☐ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Special	Removal from State	of Disposition (Name of otery, crematory or other place	eton 11/4/06	20c. Location - City or Town, State
Balt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Ligarian Service Ligaria	. Sub	Rame and Address Yough (4905)	JOLK ROad	Bulto MD 21212 Approximate
	/Medical Examiner	iner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Due to (or as a consequence b. Due to for as a consequence for as a consequence for as a consequence for as a consequence for as a consequence for as a consequence for as a consequence for as a consequence for as a consequence for as a consequence for as a consequence for a cons	an Injur	geodi as carolae or respiratory	Interval Between Onset and Death 3 weeks
8760,	icate be executed physician and s the burial-transit	icai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. So he Sh Due t' (or as a consequence d. Prevnonta	ock pe of):		3 weeks
P.O. Box 68	ath certif	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown			23d. Date of delivery Month Day Year
ords, P	w requires that the de been signed by the a should be detached t	by	Part II. Other significant conditions of Remail Laylure	ontributing to death but not resulting	g in the underlying cause giver phend Uissell greates Fall	n in Part I. 23e. Did	tobacco use contribute to the cause of death? Yes 2□No 3□Probably 4反Unknown
Vital Records,	ician: The law r certificate has be rector, page 2 sh	Completed	Ascus Dichetis	Res		1 ☐ Yes	posy prior to completion of cause of death? 22 No 1 Yes 2 No
ion of Vit	utending Physician: death. ctor: After this certifici / the funeral director.	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 XNo 27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	(Month, Day Year)	Outpatient 3 DOA Other o. Time of Injury Other	Transmigritation 3 Hes	
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not b determined	building, etc. (Specify)		City or To	(Street and Number or Rural Route Number, อพก, State)
	he Hosp in 24 hou he Fune pletely fii	edicai	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	ysician: To the best of my knowled niner: On the basis of examination and manner stated.	dge, death occurred at the time and/or investigation, in my opin	e, date and place, and due to the nion, death occurred at the time	e cause(s) and manner as stated. , date and place, and due to the cause(s)
)	To T Com	M	29b. Signature and title of certifier Whof Kliff	X MO	29c. License	1295	29d. Date signed (Month, Day, Year) 10 /≥₁ / 0 ⟨ 2
	4		30. Name and address of person who Wandy Klops 2	completed cause of death (Item 23a	a) (Type, Print) 4 g = Us St Su	Te 4362 Bo	where red 21304
	Sta Regístr	_	31. Date file& (Month, Day, Year)	32. Projistrar's Signature	Sport		

		-	For State Registrar	State of Maryland	/ Depa	artment of I	Health and M Death	lental Hyg	giene (106	35339
			Decedent's Name (First, Middle, Last)					2. Date of Dea		Vone	3. Time of Death
н	Physicia		Leila K.	Turner				Month	Day	Year	9:11A-M-
	/Medic Examin		4a. Facility Name (If not institution, give stre			4b. City, Town,	or Location of Death		4c. Cou	inty of Death	
	_ Admi	Ÿ.	WMNS - Brade	JOCK CAMI	ous	Cum	berlan	d	A	lleGA	MY
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las		If Under 1 Year Months Days		8. Date of Birt	h V- Year)	9. Birth	place (State or Foreign ntry)
	Director		220-30-9200	1 2 X F 66	Yrs.	Monano Gays	1,00.0	Dec. 0	8 193	9	MD
	p .	-	Usual Residence of Decedent 10a. State 10b. County	10c City	Town or Lo	cation					10d. Inside City Limits
	aryla sho	5	WV Hampshin				ompov				1 ☐ Yes 2 ☑ No
	the N	Director	10e. Street and Number	6		10f. Zip Code	omney	T	10a, Citizen	of What Cou	ntry?
	with						06757			LICA	,
	ns 23	Funeral	HC 79 Box 39M	. Was Decedent Ever in U.S.	. 13. \	Was Decedent of	26757 Hispanic Origin? (Spe pan, Mexican, Puerto	ecify Yes or No	- 14. F	USA Race - Ameri	
	iter d	표	1 Never Married 2 Married	Armed Forces? 1 Yes 2 No		_		Rican, etc.)		Black, White,	, etc.
99	urs a	Ď	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1□Yes 2⊠ No	Specify:		Spe	ecify: Wh	nite
Ď,	filed within 72 hours after deeth with the Maryland Hygione. ther than "natural", or itams 23s or 28s-f show the than Madical Examinar must be notified at	Completed	15. Decedent's Educa (Specify only highest grade of		16a. Dece	dent's Usual Occu	pation during most of work	ina	16b. Kind o	of Business/Ir	ndustry
2	thin 7	p de	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	ed)	9	01		7
21	ed wi	ő	12			Tead		450		ch Sch	1001
2	d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name			name)	
<u>×</u>	Men Men Merke	၉	James C. Bous				<u>Thelma</u>	Dic			. 0-1-1
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itams 23a or 28a-f show amy injury or other traumatic event, In Medical Examinat must be notified at angle.		19a. Informant's Name/Relationship (Type Leslie Connolly (daughter)			tand Number or Rura Keyser, W			wn, State, Zij	p Code)
e,	1 and Health arm 2 ther		20a. Method of Disposition	20b. Pla	ce of Dispo	sition (Name of		Date		on - City or T	own, State
Baltimore,	ages in tot l		1 ⊠Burial 2 ☐ Cremation 3 ☐ Rer	moval from State	metery, crei	natory`or other pla	111011			·	
	orthon orthon		4 □ Donation 5 □ Other (Specify) 21. Signatule of Funeral 3 rvi Licer see			en Cemet					, Maryland
Ba	Deperiment of the periment of) James A	2			ountain Ro	ad Pas	s rune adena	MD 5.	ome, P.A.
			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	ions that saused the death.	Do not ent					110 2	Approximate
	Di		shock, or heart failure. List only one Immediate Cause (Final	cause to each line.		1 ===	1				Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a conseque	ence of):	My FA	dino_				6 1795
	Examiner			,							
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque	er oe of):				-		
1	cuted nd ransii	Examiner	that initiated events c.								
Ö,	ate be executed hysicien and the burial-transit	EX	resulting in death) Last	Due to (or as a conseque	ence of):						
8760,		dicai	d.								
9	ertific ling p	₹ ¥	IF FEMALE:	. If you guitoome of program	101/					D	
Вох	ath c attend for us	lan/	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregnan 1 Live birth 2 Fetal of 4 Pregnant at time of dea	death 3[Ectopic pregnan Other (specify)	су		230.	Date of delive Month	/ery Day Year
P.O.	The law requires that the death certific ate has been signed by the attending p age 2 should be deteched for use as	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	atii J	Other (specify)					
	that the ded by detection		Part II. Other significant conditions contr	ibuting to death but not resul	lt ing in t he u	nderlying cause g	iven in Part I.	23e. Did t	obacco use o	contribute to	the cause of death?
Vital Records,	uires sign Id be	d by	END STAGE	Levor	b/s	ENSO		1 🗆	Yes 2 N	lo 3□Pro	bably 4 Unknown
202	w requir been si should I	ete	CARROMAN	x-12.1				24a. Was	an 24	4b. Were aut	opsy findings available
Re	he lav e has ige 2	Completed	- Chasilongo	LET TY					rmed?	death?	ompletion of cause of
ī	ficate or, pa		25. Was case referred to medical				26. Place of Deat	1 ☐ Yes	2.24No	1 🗆 Yes	2LI NO
>	Physiclan: r this certific ral director,	To Be	examiner?	spital:	ER/Outpatie	nt 3 DOA	ther: 4 Nursing Ho			Other (Spec	ify)
ō	tending Physician: The leath. tor: After this certificate ha the funeral director, page		27. Manner of Death		28b. Time o	f 28c. Inj	ury at	28d. Describe	how injury od	curred	
io	ath. r: Aft	ate	1 Natural 5 Pending 2 Accident investigation	(Month, Bay roal)	lary		∃Yes 2 □No				
Division	al or Attending F safter death. I Director: After d in by the funer	ertification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, st	reet, factory, office	•	28f. Location (City or To	Street and Ni wn, State)	umber or Rui	ral Route Number,
	lospital o hours aft unerel Di sly filled in	O	N //								
	To the Hospital or Al within 24 hours after or To the Funerel Direct completely filled in by	edical		cian: To the best of my know er: On the basis of examination							
	thin 2 the omple	Med	29b. Signature and title of ceptifier	and manner stated.		29c. Licer	nse number		29d. Date si	igned (Month	, Day, Year)
	To Cor			en Call	7	7	BIEFE		11011		3 3000
	-		30. Name and address of person who con		23a) (Type.	Print)	2000		NOVER	N3002_	5 2006
	3		DR. Robert Lile	11k 9025	seton	(ORIVE	Cumb	erlan	d, m	0 21	502
		ate	31. Date filed (Month, Day, Year) NOV 0 8 20	32. Redistrar's Signati	ure	frail!			7		•
	Regist	rar	140 0 0 0 20	The state of the s	-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Vear **Physician** 0818 M 2006 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE RANDALLSTOWN MD NORTHWEST HOSPITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🛛 F 57 Director 212-54-9037 20,1949 MD Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10h. County 10d. Inside City Limits 28a-f show be notified at 1 ☐ Yes 2√ No Director MD Owings Mills Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours atter death with 1 Department of Healith and Mental Hygiene. Important: If then 27 is marked other than "nature." ö 8 Whispering Court 21117 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No þ Specify. 3 Widowed 4 Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Administrative Secretary Garrison Forest School 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Howard Adam Palmer Awbrey Leland 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alan Torbit Husband 8 Whispering Court, Owings Mills, MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 11/9/06 Dulaney Valley Mem. Timonium, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Sto Eline Funeral Home, Reisterstown, MD 21136 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) VENTRI CULM Physician TACHY CALSIA /Medical Due to (or as a consequence of): Examiner SCHEM 10 ARDIOM YOPATMY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ WELLIT 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 200 No Inpatient 2 ER/Outpatient 3 DOA မ After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural Injury 5 Pending investigation within 24 hours after deau... To the Funeral Director: After the function of 1 Tyes 2 TNo 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c, License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

NOV 0 8 DHMH 17 Rev 1/2001

MAHE SHWARI

31. Date filed (Month, Day, Year)

553910

NORTHWEST HOSP CTR, RANDALISTOWN, MD

MS

gistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

MD

		•	For State	State of Mai	ryland / Depa <i>Ce</i>	artment of H rtificate of L			2006	35341
			Registrar 1. Decedent's Name (First, Middle, Las	.t)				2. Date of Death		3. Time of Death
	Physicia	an	Margaret	Tyler				October 2	25. 2006	5:40PM ^M
	/Medic Examin	_	4a. Fecility Name (If not institution, give			4b. City, Town, or	Location of Death		4c. County of Dea	th
	Examin	eı	FutureCare Cher			Re	isterst o w	n	Balti	imore
	Funeral		5. Social Security Number 6. Se	ex 7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	9. Bir	thplace (State or Foreign ountry)
	Director		185-28-5472	□M 2[XF	71 Yrs.	Month's Days	Tiodis Will.	Sept. 19	, 1935	PA
	P .		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	nation				10d. Inside City Limits
	arylar shov	ا ج								1 □ Yes 2X□ No
	88e-1	Director	MD Baltimo	re	Keis	10f. Zip Code		100	g. Citizen of What Co	ountry?
	with t			. /2/		Tot. Zip Code	21136		USA	,
	within 72 hours after death with the Maryland jiene. Than "natural", or Items 23a or 28e-f show I're Meulcal Exaciline invat be notified at	Funeral	300 Cantata Cour	12. Was Decedent Ev	ver in U.S. 13.	Was Decedent of H If Yes, specify Cuba		ecify Yes or No-	14. Race - Ame	
_	Iter d	Ë	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🔯 No				Rican, etc.)	Black, Whit	e, etc.
315-0036	hours after tural', or Ite	by	3 ☐ Widowed 4 🛣 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🖾 No	Specify:		Specify:	White
	2 ho	Completed	15. Decedent's Ed (Specify only highest gra		16a. Dece	dent's Usual Occup	ation during most of work	ina 16	6b. Kind of Business	/Industry
7	within 72 ene. than na	npie	Elementary/Secondary (0-12)	College (1-4or 5+	+)	kind of work done of DO NOT use retired	1)			
7	er th	5		1	T	ailor		45	Clothing	
2	be filed vital Hygie of other l	Be (17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, Ma	uden Sumame)	
Maryland	7 6 0 13	၉	Raymond Arthur P					arie Wil		7:- 0:- (t.)
<u>a</u>	2 sh and Is m		19a. Informant's Name/Relationship						City or Town, State, .	ZIP COde)
_	as 1 and 2 should of Health and Me litem 27 Is mark r other traumatic		Rochelle LaRue Ty	ler Daugh		FM 609,			78945 Oc. Location - City or	Town, State
0	ges tof H		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 ☐		1	osition (Name of matory or other place	(θ)	2.406		
	t. Pa rtmen rtent:		' 4 □ Donation 5 □ Other (Specification of Experies Linear Linea			Cremation 2. Name and Addre			Hampstead	
Baltimore,	permit. Pages Department of H Importent: If its any injury or of		21. Signature of Funeral Service Licer	M. Jer	Kin	Eline Fun			Reisters erstown, l	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused to	the death. Do not en	ter the mode of dyin	ng, such as cardiac	or respiratory arres	it,	Approximate Interval Between
	Pnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	. Meta	static consequence of):	Breast	Can	Cer		Onset and Death
		e	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of):					
	uted d ansit	Examin	Sequentially list conditions, if any, leading to immediate cause. Litter to Julying Cause (Disease or injury that initiated events	c						
ó	an an rial-tr		resulting in death) Last	Due to (or as a	consequence of):					
8760,	cate be executed physician and the burial-transit	dicai		_ d						
9	e as t	0	IF FEMALE:	20- 16					201 5 11 11	
). Box	Physicien: The law requires that the death certific this certificate has been signed by the attending trial director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnent at the sum of th	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)	<i>'</i>		23d. Date of de Month	Day Year
P.O.	d by	Ph.	Part II. Other significant conditions of	contributing to death bu	ut not resulting in the	underlying cause giv	ren in Part I.	23e. Did toba	acco use contribute !	o the cause of death?
Division of Vital Records,	w requires that been signed to should be det	ed by						1 ☐ Yes	3 2 □ No 3 □ P	robably 4 Unknown
000	ne law re has bee ge 2 sho	Completed						24a. Was an autopsy	prior to	utopsy findings available completion of cause of
ď	ysicien: The lis certificate hadirector, page	, E						perform 1 ☐ Yes 2	ed? death? No 1 ☐ Ye	s 2 No
ita	icien: Th certificate rector, pag	Be (25. Was case referred to medical examiner?					h (Check only one		
Ž	Physic this ca al dire	ို	1 ☐ Yes 2 No	Hospital: 1 Inpatier		ent 3 DOA			nce 6 Other (Spe	ecify)
Ē	Jing P. After t funera	on:	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y Year) 28b. Time Injury	Wo	rk? Yes 2 □ No	28d. Describe hov	V Injury occurred	
sio	Attending or death. ector: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be	OB Place of Inju	ıry - At home, farm, s		163 2 2 110	28f. Location (Stre	eet and Number or F	Rural Route Number.
Ξ	or Attendated of the of	Certification:	4 Homicide determined	building, etc	c. (Specify)	itest, lactory, office		City or Town,		
	To the Hospital or Attending Physikin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical C	29a. Certifier 1 Certifying Pl (Check only 2 Medicel Exa-	hysician: To the best of miner: On the basis of and manner sta	examination and/or i	ith occurred at the ti nvestigation, in my o	me, date and place, opinion, death occur	and due to the car red at the time, da	use(s) and manner a te and place, and du	is stated. e to the cause(s)
	To th comp	Me	29b. Signature and title of certifier			29c. Licens	se number	29	d. Date signed (Mon	th. Day, Year)
			Myles	uhm	·M	000	63534	0	clober,	20,000
3	1		30. Name and address of person who Mandana	Shahba		. Print) 5 mai	in stree	T Re	igsterst.	26,2006 ow n
	St	ate	31. Date filed (Month, Day, Year)	32. Redistra	ar's Signature	Level 1			9	
	Regist	rar	NOV 0.8	2006	was At 1					

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 35342

			1- For State Registrar			Cei	rtificate d	of D	eath					Reg. No	20	00	0004
Phy dical Ex	sicia	an/	1. Decedent's Name (Firs										Month	Day	Year	3	. Time of Death 1118 hrs
Gicai Ex	(allill	_	4a. Facility Name (if not in		-	ımher)	•	4h	City, Tow	n orlo	cation of		October		. County of	Death	
			Merritt Boulevard			umber /			Oundall		ocation of	Death			Baltimore		:у
Fund	eral		5. Social Security Numbe	r 6. Se	∋x	7. Age (In yrs. I	ast birthday)	<u>'</u>	If Under 1	Year	If Under	24Hrs.	8. Date of E	lirth (MM/	DD/YYYY)		lace (State or Foreign
Direc			215-84-48	40 ₁ X	M 2 F	37	Y	rs	Months	Days	Hours	Min	Dec.	6,	1968	Count	D)
			Usual Residence of Dece	dent													
	any		10a. State 10b. (County		10c. City,	Town or Loc	ation								1	0d Inside City Limits
pu .	show nce.	۱	MD			Ва	ltimo	re	Cit	У						1	Yes 2 No
aryla	8a-f	둜	10e. Street and Number					- 1	Of Zip Co				Ī	10g Citiz	zen of What	Country	/?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be flied within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	s 23a or 28a-f show a	Director	1622 Park	man A	venue				2123	30				USA	L.		
with	ns 23	Funeral	11. Marital Status		A of E	cedent Ever in U							cify Yes or N	lo-			n Indian, Black,
death	r ite	Š	1 X Never Married 2	Married	1 Yes	2 X No	11	res,	specily C	Jupan, I	viexicari, i	ruello K	ican, etc.)		White.	etc.	
ffer	ner n	by F	3 Widowed 4	Divorced	If Yes, Give Ye or Dates:	ar	1	Ye	es 2 X	No	specify:				Specify:	Wh	ite
ours	atura	9	15. Decedent's Education	on (Specify o		de completed)	16a. Deced		Usual Oc					16b. H	(ind of Busi	ness/Ind	ustry
72 h	E E	e e	Elementary/Secondary	(0-12)	College (1-4 or 5+)	daning	most	OI WOIKII	ig ille. L	ONOTO	30 1011101	۷,				
03 ithin	r je je	Completed	9				C	ar	pet						Carp	ent	ry
5-0 led w Hygin	the		17. Father's Name (First,	Middle, Last)	_				18	.Mother's	Name (F	irst, Middle	Maiden	Surname)		
21 be fi	ent.	a	Milton R.								Mary						
21 nould	is ma	유	19a. Informant's Name/Re	elationship (1	ype, Print)								ral Route N				
M Z sl	n 27 numa		Mary Wito		- Mot		326	S	. Le	hi	gh S	t.,	Bal:	imo	re,	MD	21224
re , and the Hea	fiter er tra		20a. Method of Disposition		Removal f		Place of Disp crematory or			of ceme			Date 4 - 0 6		Location - C		
mo Page:	r oth		4 Donation 5 C		_		cred :	He.	art	of				B	alti	mor	e, MD
alti mit.	porta ury o		21. Signature of Funeral				22	Nam	ne and Ad	ldress o	f Facility	Bra	dlev-	-Ash	ton	Fun	eral Hom
m % 9	里記		Robert 1)	Soll	5	_							Sprin				
Physic	cian		23a. Part I. Enter the dise			caused the death											Approximate Interval Between Onset and
/Med	_		Immediate Cause (Final		Multiple In	juries											Death
Exami	mer		or condition resulting in o		Due to (or as	a consequence o	of):										
		.	Sequentially list condition	ns, b.												_	
		iner.	if any, leading to immedia cause Enter Underlying		Due to (or as	a consequence o	of):										
	\overline{D}	Examine	(Disease or injury that initiation events resulting in death	itiated C	Due to (or as	a consequence o	of):									\dashv	
P /g	ransit	ũ		, d													
, e eve	physician and the burial - transit	an/Medical	UNPENDED		AMENDED											- 1	
760 cate b	physi the bu	Me	IF FEMALE.	ant in the		outcome of preg	nancy						*	230	d Date of de	elivery	
687 ertifi	as as	- ≿	23b. Was decedent pregn past 12 months?	ant in the	1 Live		andh —	Fetal	death	3	Ectopic	pregnand	СУ		Month	Day	y Year
o X	e attendi for use	Physicia	1 Yes 2 No 9	Unknow		nant at time of de	eath 5	Other	(Specify	1)							
D .the d	y the	Ph	Part II. Other significant	conditions		College Tellplane Co.	esulting in the	e und	leriving ca	ause aiv	en in Par	t I.	23e. Did	tobacco	use contribu	ute to the	e cause of death?
P. S. That	signed by the a	ð							, ,	3			1 Y	es 2	No 3	Probab	oly 4 Unknown
JS,	uld b	Completed											24a Wa	s an	1 24b. We	ere autor	osy findings available
OF B	e 2 should	gle												opsy formed?		or to con ath?	npletion of cause of
Rec	cate	5											1 🗸 Yes		p	/ Yes	2 No
Ezi iii	certificate ector, page	Be (25. Was case referred to examiner?		Hospital:		2			Io	f Death (-	_			
is y	:E :E	은	1 🗸 Yes 2	No	Hospital: 1	Inpatient 2	ER/Outpatie						Home 5		nce 6 🗸		cene
ling I	After this funeral dir		27. Manner of Death 1 Natural 5		28a. Date	e of Injury th Day Year) , 2006	28b. Time of 1115 hrs	of Inju	iry 280		at Work?	_ In	8d. Describi				truck
ior trend death	ector: by the	atic	2 Accident	Pending Investigat	ion						s 2 🗸						
ivis or A	Direct In by	tific	3 Suicide 6	Could not	be	ce of Injury - At h	iome, farm, st	reet, t	factory, o	ffice bui	lding, etc	. 2	8f. Location or Town,		ind Number	or Rural	Route Number, City
D spital ours	filled in	Certification:	4 Homicide	determine	d (Specify	Major Roa	d / Highwa	ау				ĺΜ	lerritt Boule	evard @	Ives Lane	e, Dund	alk, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	Fur		conclusion in		"	est of my knowled of examination a	_										
To the within	To the	Medical	2		and manner		Z. IGIOI II IVOSLI	94001				anou at 1					
35		Σ	29b. Signature and title of	or certifie	1						number				_		n, Day, Year)
			- //	1	16				'	D.C.M	.E.			Nov	ember 1	, 2006	
- 9	n		30 Name and dress of			,							. 0.425 :				
)		Mary G. Ripple I			Medical Exa		11 F	-enn Si	treet,	Baltimo ———	re, ME	21201				
	Si Regis	tate	31. Date filed (Month, Da	y, Year)		strar's Signat	ure Page de	200	B B								

URIGINAL

Pages 1 Box 68760.

State of Maryland / Department of Health and Mental Hygiene 006 35343 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Phyllis Ruth Tallon 12:10 P^M 5, 2006 November /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Memorial Hospital Havre de Grace Harford Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2K☐ F Months 410-658-5701 Director 63 June 13, 1943 Virginia Usuel Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f ehow ir then "natural", or itame 23a or 28a-f eho 1 Yes 2 No Director Maryland | Cecil Rising Sun 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 100 McNamee Lane 21911 Apt. 404 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 7 I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Own Home jes 1 and 2 should be filed of Health and Mental Hygin If Item 27 is marked other or other treumatic event, marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Maxwell Bandy Sally Beatrice Hall 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) James E. Tallon / Husband 100 McNamee Lane Apt. 404, Rising Sun, ND 21911 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition IX Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 permit. Page Depertment of Important: If any injury or once. 4 □ Donation 5 □ Other (Specify) Dublin Missionary Bapt. 11-8-06 Darlington, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A.
1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on pach line. Approximate Interval Between Onset and Death Immediate Cause (Final claus **Physician** leun disease or condition resulting in death) /Medical Examiner tuks eensitus Sequentially list conditions, if any leading to in rediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sicien and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) attending physicien for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Day Month Year 5 Other (specify) 4☐Pregnant at time of death P.O. signed I I be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by Myelama 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No certificate Division of Vital director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ۵ SiQ! 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: After Hospital or Attending 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 TSuicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours e To the Funerel [Contifying Physician: To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) collian 5/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Kamnidy Milineum un ich Revolution St Harre De Greuch 32. Regetrar's Signature NÖV State Ó 8 2006 Willes-Registrar

			For State Registrar	State of M	laryland		artment of H		ınd Mei		ene 0	06	35344
	Physicia	an	Decedent's Name (First, Middle, Last,				WITERREDO			Date of Death Month	Day	Year	3. Time of Death
	/Medic Examin		ETTA 4a. Facility Name (If not institution, give	street and number)		INTERBERG 4b. City, Town, or			10VEMBEI	R 3 21	006 of Death	7:00 A M
	LAdimir	CI	AUTUMN HILL				FULTON				HOWA	RD	
	Funeral Director		115-12-8354	7. A	ge (In yrs. Ia 91	st birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours		Date of Birth (Month, Day,) 5/05/19	15	9. Birthp Cour	place (State or Foreign ntry) NY
	yland		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation					1	10d. Inside City Limits
	Ba-f et	ctor	MD HOWARD			COLUM			·				1 Tes 2 No
	with the a or 2	Funeral Director	10e. Street and Number 6457 BRIGHT PLUME	:			10f. Zip Code 2104	4		10	g. Citizen of V		ntry?
	deeth	nera	11. Marital Status	12. Was Decedent Armed Forces		6. 13.	Was Decedent of H		gin? (Specif	y Yes or No-	14. Rac		can fndian,
Maryland 21215-0036	within 72 hours after deeth with the Maryland ene. then "naturel", or Itema 23a or 28a-f ehow the Medical Exandrar must be notified at	ρ Σ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 If Yes, Give X Year or Dates:	No		1 □ Yes 2 No	Specity:	, i dello i lic	all, etc.)	Specify	1	WHITE
15-0	"natur	Completed	15. Decedent's Edu (Specify only highest grad	cation e com <i>pleted)</i>		(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most	of working	10	6b. Kind of B	usiness/In	dustry
212	d withir piene. r then	ошо	Elementary/Secondary (0-12)	College (1-4or	5+)	CUTTE		,			WHOLE	SALE	MFG.
ng L	be filed ta! Hyg d other	Be	17. Father's Name (First, Middle, Last)		COL					irst, Middle, Ma	aiden Suman	- /	OROWITZ
ryla	hould d Men marke	2	JACK 19a. Informant's Name/Relationship (T)	roe Print)	GUI	LDBERG	ng Address (Street	ROSI		loute Number	City or Town		
e, Ma	1 and 2 s Health an In 27 le		RITA COHEN / DAUG	HTER	20b Pla	6106	FORESTVA	LE COU	URT -	COLUMB	IÁ, MD	2104	14
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel; or Itema 23a or 28a-f show suppring to other traumatic event, the Medical Examinar must be multiled at <u>once.</u>		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	LIBER	AKI Z.	sition (Name of natory or other plac RK CEMETE ON CONG.		1/05/	2006	RANDAL	LST0	WN, MD
Ball	Depermit Depermit Import eny in		21. Signature of Funeral Service Licens	Z			Name and Address		JUL	LEVINS DAD - P			, INC. MD 21208
	Physician		23a. Part1. Enter the disease, or compi shock, or heart failure. List only o Immediate Cause (Final disease or condition	icetions that cause ne cause on each	line.		er the mode of dyin		cardiac or re	espiratory arres	st,		Approximate Interval Between Onset and Death SUDDEN
	/Medical Examiner		resulting in death)	Due to (or a	s a conseque	ence of):	/E HEART		RE				YEARS
7	outed id ansit	ımlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events	Due to (or a	s a conseque COR		ARTERY D	ISEAS	E				YEARS
8760, <	ate be executed obysicien and the burial-transit	cal Exa	resulting in death) Last	Due to (or a	s a conseque	ence of):							
9	ntificat ng phy s as th	Medi	IF FEMALE:										
O. Box	thet the death certificate ed by the attending phys detached for use as the	Physician/Medical Examiner	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	déath 3[Ectopic pregnancy Other (specify)					te of deliventh	ery Day Year
ds, P.O.	juires thet the n signed by th ald be detache	ρ	Part II. Other significant conditions co	ntributing to death	but not resul	lting in the u	nderlying cause giv	en in Part I.		23e. Did toba		ribute to t	he cause of death?
Vital Records,	The law requires ate has been signi page 2 should be	Completed								24a. Was an autopsy perform 1 Yes 2	ed?	Were auto prior to co death? 1 ☐ Yes	opsy findings available impletion of cause of
/ital		Be	25. Was case referred to medical examiner?						of Death (C	Check only one)		
o	문 등 교	2	1 ☐ Yes 2 💢 No 27. Manner of Death	lospital: 1 ☐ Inpat 28a. Date of Inj		R/Outpatier		4 🗌 1901	-	5 Residen			GROUP HOME
<u>o</u>	Attending is r death. ector: After by the funer	atlon	1 Natural 5 Pending 2 Accident investigation	(Month, D	ay Year)	Injury	Wor	k? Yes 2⊡N			,		
Division	al or Atte setter des l'Directo d in by th	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Ir building, e	njury - At hor etc. <i>(Specify)</i>	me, farm, sti	reet, factory, office		28f	Location (Stre City or Town,		er or Run	al Route Number,
	To the Hospital or Attenwithin 24 hours efter deati To the Funeral Director: completely filled in by the	cal	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	ner: On the basis	of examination	ion and/or in	vestigation, in my o	pinion, deat	th occurred	at the time, dat	e and place.	and due to	o the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c. Licens	e number	_	29	d. Date signe	d (Month,	Day, Year)
,				ampleted '	d= 40 H.	20+1 CT	1)2	289	51	1	oven	Car :	5, 2006
	(i		30. Name and address of person who could be seen and selection of the seen and selection of the seen and selection of the seen and selection of the seen and selection of the seen and selection of the seen and selection of the seen and selection of the seen and selection of the seen and selection of the seen and selection of the seen and selection of the seen and selection of the seen and selection of the seen and selection of the seen and selection of the selection of the seen and selection of the selection of	E So	death (Item	Sa) (Type,	HG PATCE	sent	Ph	, Colem	eles,	do.	1 21044
	Sta Registi	ite 'ar	NOV 0 8 2	006 32. Hasis	trans Signati	IF A	parti						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiens, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 6:45PM enato Ventura November 03 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Maryland Medical 1 Sex 7. Age Systems if Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** YORK Director 08 1921 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at PINELLAS 1XYes 2 No TARPON SPRINGS **Funeral Director** 10e, Street and Number 10g. Citizen of What Country? 23a or 2 USA EGRET Pages 1 and 2 should be filed within 72 hours after death 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 No 1941 – If Ves, Give Year or Dates: 194 ← 1 ☐ Never Married 2 Married o. Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 🕱 No à 3 ☐ Widowed 4 ☐ Divorced 1945 "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) CANANDAIGUA Elementary/Secondary (0-12) College (1-4or 5+) NURSE VETERANS HOSPITAL permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If Item 27 is marked other that any injury or other traumatic event, the once. 2 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SANTE VENTURA DiPRONIO Domenica 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) TARPON SPRINGS, IEL 34689 Patricia VenTURa 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State CARROLL CREMOTION, INC 11/6/2006 HAMPSTEAD, MO 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee

22. Name and Address of Facility of William Bruke

23. Name and Address of Facility of William Bruke

24. Name and Address of Facility of William Bruke

25. Name and Address of Facility of William Bruke

26. Name and Address of Facility of William Bruke

27. Name and Address of Facility of William Bruke

28. Name and Address of Facility of William Bruke

29. Name and Address of Facility of William Bruke

29. Name and Address of Facility of William Bruke

29. Name and Address of Facility of William Bruke

29. Name and Address of Facility of William Bruke

29. Name and Address of Facility of William Bruke

29. Name and Address of Facility of William Bruke

29. Name and Address of Facility of William Bruke

29. Name and Address of Facility of William Bruke

29. Name and Address of Facility of William Bruke

29. Name and Address of Facility of William Bruke

29. Name and Address of Facility of William Bruke

29. Name and Address of Facility of William Bruke

29. Name and Address of Facility of William Bruke

29. Name and Address of Facility of William Bruke

29. Name and Address of Facility of William Bruke

29. Name and Address of Facility of William Bruke

29. Name and Address of Facility of William Bruke

29. Name and Address of Facility of William Bruke

29. Name and Address of Facility of William Bruke

29. Name and Address of Facility of William Bruke

29. Name and Address of Facility of William Bruke

29. Name and Address of Facility of William Bruke

29. Name and Address of Facility of William Bruke

29. Name and Address of Facility of William Bruke

29. Name and Address of Facility of William Bruke

29. Name and Address of Facility of William Bruke

29. Name and Address of Facility of William Bruke

29. Name and Address of Facility of William Bruke

29. Name and Address of Facility of William Bruke

29. Name and Address of Facility of William Bruke

29. Name and Address of Facility of William Bruke

29. Name and Address of Facility of William Bruke

29. Name and A 22. Name and Address of Facility JN ZUMB NW FIT 4 MON CO 6028 Sykesville Road Elbers BURG MO 21784 **Physician** Tastro intestinal 5 days disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leaving Lammediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Munknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performe 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Deat 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours at To the Funeral I 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

University of maryland Medical Center

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8 2006

allagher

32. Registrar's Signature

DHMH 17 Rev 1/2001

b

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 26 per verb. G861, II/14/06dhb
State of Maryland / Department of Health and Mental Hygiene (1) 6

Amend Item 26 per verbal, 11/08/06dhbC861

Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician WElls KANDO Cph We mber 4c. County of Peath 2006 GORY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Losedale vale anklir Year If Under 24 Hrs. Birthplace (State or Foreign Country) Age (In yrs. last birthday) Social Security Number **Funeral** Months Days Hours 72 5208 M 2DF 9 Yrs. Director MARYIAND Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryla Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any fujury or other traumatic event, the Medical Examinar must be notified a once. 1 Tes 2200 BAIMMORE nottingham Director MAYIMO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? AUEN 21236 USM 129 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1. No li Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 40 2 Specity: Black Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry KESI OGAHAL Elementary/Secondary (0-12) College (1-4or 5+) NIGht MANAGET Universit 12 the grade Morgan State 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be WELLS Louisny 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AVEN NoHINGhow. MANY /AND MAKINA WELL Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Girpus 22. Name an Address of Facility Charman Alam's trues Wha 21. Signature of Funeral Service Licenses MISTERS FOUND NEME The date Muli 23a. Part. Enter the thease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart kilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 40 cardia /Medical **Examiner** hemit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner ending physicien and use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of). of Vital Records. P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sign, page 2 should be 3 Probably 4 ₩hknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Very hual sascular 1□ Yes 2√2No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 6 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2X ER/Outpatient 3 □ DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours e To the Funeral D the Hospital 1by Carrifying Physician: To the best of my knowledge ideath occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 235 Cutifier completely (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier De022583 1 November 7, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 Lock laver Blod. Baltimore Up 21239 David J. Narman 32. Registrar's Signature 31. Date filed (Month, Day, Year) NOV 0 8 2006 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3^{Day}20<u>06</u> 03 10:00AM LINDA JOYCE WILLIAMS NOV. 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) BALTIMORE CITY N/A1518 N. SMALLWOOD STREET If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 58 219-50-1637 02/06/1948 MARYLAND Usual Residence of Decedent 10d. Inside City Limits 10h Counts 10c. City, Town or Location 1 Yes 2 No N/A BALTIMORE CITY 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21216 USA SMALLWOOD STREET 1518 N. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Never Married 2 ☐ Married 1 ☐ Yes XXNo If Yes, Give Year or Dates: BLACK 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) STATE OF MARYLAND Elementary/Secondary (0-12) College (1-4or 5+) 2 YEARS YOUTH SUPERVISOR III 12TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) SAMMIE CREECH AMY M. CREECH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 3821 GREEN ASH CT., RANDALLSTOWN, MD 21133 MARY LEWIS / FRIEND 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 Cremation 3 Removal from State 11/07/06 WOODLAWN CEM. BALTIMORE CO., MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 21. Signature of Ferral Service Licenses LIBERTY HEIGHTS AVE, BALTIMORE, MD ter the disease, or complications that caused the heart failure. List only one cause on each line Approximate Interval Between Onset and Deat not enter the mode of dying, such as cardiac or respiratory arrest, Immediae se (Final disease of condition resulting in death) mon Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 □Unknown 1 Yes

Physician /Medical Examiner

Department o Important: If any injury or

Physician

/Medical

Examiner

10a. State

Funeral Director

Be Completed by

2

MD

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hyglene.

Int: If item 27 Is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Examiner physician and s the burial-trans Physician/Medical attending p for use as been signed b should be deta þ Completed cate has page 2 s Be Certification: To

certificate

To the Hospital or Attending Physician: within 24 hours after death.

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760.

IF FEMALE 23b. Was decedent pregnent in the past 12 months? 1 ☐ Yes 2 D No

gistrar's Signatur

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed

od to inodiodi				o. I lace of Death (Check dinadile)
10	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other:	4 ☐ Nursing Home	e 5 Residence 6 Other (Specify)
5 ☐ Pending investigatio	28a. Date of Injury (Month, Day Year) n	28b. Time of Injury	28c. Injury a Work? I 1 ☐ Ye		d. Describe how injury occurred
6 Could not be determined		oome, farm, street, fa	actory, office	28	if. Location (Street and Number or Rural Route Number, City or Town, State)
1 Lertifying Pl	hysician: To the best of my kn	owledge, death occi	urred at the time	, date and place, an	nd due to the cause(s) and manner as stated.

one)		and manner stated	
29b. Signature and title	of certifier	1	
		01/	

NOV 0

ed (Month, Day,

8 2006

25. Was case referred to medical examiner?

f Death

1 ☐ Yes

1 Matural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who

State Registrar

Medical

Veal

Black, White, etc.

Month

Day

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ⋈ No

Year

2006

4:16 P M

Birthplace (State or Foreign Country)

Washington, DC

10d. Inside City Limits

Approximate Interval Between Onset and Death

7 months

1 X Yes 2 ☐ No

Registrar DHMH 17 Rev 1/2001 Maria

To the Hospital on within 24 hours after To the Funeral Discompletely filled in

State Registrar

29c. License number

29d. Date signed (Month, Day, Year)

MD051246L

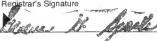
00 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Walter Reed Medical Center Washington,

Marleigh Erickson, LTC MC USA

31. Date filed (Month, Day, Year)

NOV 0 8 2006



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 5th 200 November en oh Dard /Medical 4a. Eacility Name (If not institution, give street and number), 4c. County of Death Town, or Location of Death Examiner pital Baltmore City If Under 1 Year 8. Date of Birth (Month, Day July 18 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months 1 XM 2 ☐ F 79 18,1927 112-20-0660 New York Director Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10b. County ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1X Yes 2 No MD Director Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1309 W. Northern Parkway 21209 USA 14. Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 🔀 No Maryland 21215-0036 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Publishing 12 Indexer 12 should be filed w n and Mental Hygier 7 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be t and 2 should by Health and Menta Royce Ward Madeline Smith ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:
Department of Health at
Important: If item 27 is
any injury or other trau 1309 W. Northern Parkway-Baltimore, Maryland 21209 James C. Silvan-friend Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 20a. Method of Disposition EVANS FUNERAL CHAPEL AND 1 ☐ Burial 2 ☐ remation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State Forest Hill, Maryland CREMATION SERVICES BFT. ATR 21. Signature of Funeral Service Licenses 22. Name and Address of Facility EVANS FUNERAL CHAPEL AND CREMATION 8800 Harford Road-Parkville, MD 21234 SERVICE **SERVICES** -conducte Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease in july) that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No ed by the 9□Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ HO 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate spirator 2 No 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case re erred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 7 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Dispatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐Pending investigation (Month, Day Year) 1 Natural
2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🗓 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death m 23a) (Type, Print) amarina

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NOV 0 8 2006

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene.

White, Charles

Phy: /M Exa

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Division of Vital Records, P.O. Box 68760,

		For State Registrar		S	tate of I	Marylan		partmei <i>ertifica</i>				Mental Hy	ygie Reg.	200	6	353	151
hysici		1. Decedent's Name Charles										2. Date of D Month	eath		oar 06	3. Time o	of Death
/Medio Examir		4a. Facility Name (I				ər)		1 1	Town, or	Location	of Death	00000		4c. County of	Death	7.00	<u> </u>
uneral rector	- 3	2401 Eag 5. Social Security N 229-52-3	umber	6. Sex		Age (In yrs.	last birthda Yrs	y) If Unde	der 1 Year If Under 24 Hrs. 8. Date of Birth					9	Birthn	lace (State	or Foreign
		Usual Residence of 10a. State		1		10c. Cit	y, Town or	Location				bepe.		1714	. ,	Od. Inside C	City Limits
28e-f sh	Director	Md.		arfor	d		Bel Air							1 Tyes 2			
3e or	al Dir	10e. Street and Nur 2401 Eag		w Dri	ve		10f. Zip Code 21015						10g. Citizen of What Country? U.S.A.				
Important: If item 27 is marked other than "netural", or Items 23e or 28e-f show any injury or other traumatic event, the Madical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Marri 3 Widowed	ied 2 ∰ Mar	ried 12.	Was Decede Armed Force 1 ☐ Yes 2 [If Yes, Give Year or Date	s? ₹No	Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica						or No- 14. Race - American Indian, Black, White, etc. Specify: white				
than "netura he Madical I	Completed	(Spec	15. Deceder ify only highe ndary (0-12)	st grade co		or 5+)	(G.	cedent's Usu ve kind of w b. DO NOT o	ork done d ise retired,	luring mos)	st of work	ing		. Kind of Busin		dustry	
ked other ic event, t	To Be Co	17. Father's Name (,			S	pray p	Paliic	18. Moth		e (First, Middle Ltchell	a, Maio				
n 27 is mar er traumat	-		19a. Informant's Name/Relationship (Type, Print) Rose B. White/wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2401 Eagle View Drive, Bel Air, Md. 21015														
ant: If iten ury or oth		20a. Method of Disposition 1 ABurial 2 Cremation 3 Removal from State 1 A Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Bel Air Mem. Gdns. 11/2/2006 Bel Air, Md. 21. Signature of Funeral Service Licensee Contact of Date contact or City or Town, State 11/2/2006 Bel Air, Md.															
Import any inj once.		21. Signature of Fu	neral Service	Licensee	ul	eu								1 Air,			
sician edical miner	Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Approximate Inter															
physician and s the burial-transit	edical Exa	Due to (of as a consequence of): d. Conomany artery disease															
After this certificate has been signed by the attending funeral director, page 2 should be detached for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1											23d. Date of delivery Month Day Year				
an signed b uld be deta	by	Part II. Other signifi	icant conditi	ons contribi	uting to death	but not resu	ulting in the	underlying (ause give	n in Part I			tobacc Yes	pacco use contribute to the cause of death?			
cate has been page 2 sho	Completed				····							24a. Was auto perfe 1 \(\text{Yes}		prior	r to con	esy findings apletion of c	available ause of
fter this certific ineral director,	To Be	25. Was case referrexaminer? 1 Yes 2 27. Manner of Death 1 Natural	No	Hosp 2	ital: 1 □ Inpa 8a. Date of Ir (Month, L	njury	ER/Outpat 28b. Time Injun	of :	Othe 28c. Injury Work	r: 4 □ Nu	ırsing Ho	me 5 Res 28d. Describe	idence		Specify)	
To the Funerel Director: A completely filled in by the fu	Certification;	2 Accident 3 Suicide 4 Homicide	investi 6 Could determ	gation not be	8e. Place of I building,	njury - At ho etc. <i>(Specif</i> y	ome, farm,	M street, factor		′es 2□	-	28f. Location (City or To		and Number o	r Rurai	Route Num	ber,
the Funer pletely filk	Medical (29a. Certifier (Check only one)	1 Certifyir 2 Medical	examiner:	n: To the be On the basis and manner	or examinal	wledge, de tion and/or	ath occurred investigation	at the time, in my opi	e, date an inion, dea	id place, a	and due to the ed at the time,	cause date a	(s) and manne and place, and	r as sta due to	ited. the cause(s)
com	Σ	29b. Signature and	title of certifie	'ue/	NO			29	. License	number	61		29d. [Date signed (N	Sonth, E	Day, Year)	
Sta	te		ee 1 h, Day, Year)	10	66	death (Item	2006	Print)	u	5/1	Ho	erne	de	Gra	ce	MI	2
Registr		NO		2006	Blown	J. B.	A.	and I							2	10/	5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of	Maryland / [tment of F		and Mental H	ygiene Reg. No?	0.6	35352		
	Physici	an	1. Decedent's Name (First, Middle, Vesta Theresa						2. Date of D Month Octobe	r 31 2	20°08	3. Time of Death		
	/Medic		4a. Facility Name (If not institution,		oer)		4b. City, Town, o	r Location (y of Death	4:45pm		
	Examin	er	Manor Care Nur	-	•		_	son	, Douti		Baltimore			
	Funeral Director		5. Social Security Number 213-72-6159 Usual Residence of Decedent	3. Sex 7. 1 □ M 2√√F	Age (In yrs. last bir.		If Under 1 Year Months Days	If Under Hours	Min. 8. Date of B Month C April	irth (1908)	9. Birthpi Coun	lace (State or Foreign fry) PÅ		
	yland now		10a. State 10b. County		10c. City, Town	or Loca	tion				11	0d. Inside City Limits		
	e Mar	ctor	Maryland Balt	imore	Kir	igsvi	ille					1 □ Yes 2√√No		
	within 72 hours after death with the Maryland ene. than "neturel; or items 23a or 28e-f show the Medical Evaniner mast be notified at	Funeral Director	10e. Street and Number 1 Batter Brook	C+			10f. Zip Code	087		10g. Citizen of		try?		
	ns 23	erai	11. Marital Status	12. Was Decede	ent Ever in U.S.	13. Wa			gin? (Specify Yes or N		S.A.	an Indian		
စ္	or iter	Fun	1 ☐ Never Married 2 ☐ Marrie	Armed Force	es? ☑No				gin? (Specify Yes or N n, Puerto Rican, etc.)	Bla	Black, White, etc.			
8	uref.	d by	3 Widowed 4 □ Divorced	Year or Date	9S:		Yes No			Specii	whi			
5	in 72 in net	piete	15. Decedent's (Specify only highest	grade completed)		(Give kir.	nt's Usual Occup nd of work done ONOT use retire	durina mos	t of working	16b. Kind of E	6b. Kind of Business/Industry			
212	giene.	Completed	Elementary/Secondary (0-12)	College (1-4	lor 5+)	Home	emaker			Own	Home			
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Importent: If Hem 27 is marked other than "neturel; or items 23a or 28e-1 show eny injury or other traumatic event, the Medical Examiner must be notified at OREs.	Be	17. Father's Name (First, Middle, La						er's Name (First, Middl	e, Maiden Sumai	den Sumame)			
<u> </u>	should Ind Men marke	2	Nicholas Shank Mary Schirf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number,											
Ma	nd 2 shallth and 27 Is m		Thomas Weyant /									•		
J.	permit. Pages 1 and 2 Department of Health a Importent: If Item 27 Is eny injury or other tra QRCE.		20a. Method of Disposition		20b. Place of	Dispositi	ion (Name of tory or other place	28)	Kingsvill Date	20c. Location	- City or To	wn, State		
<u>Ĕ</u>	ment ment tent: It		'4 □ Donation 5 □ Other (Spe		419			- 1	11/4/2006	Elbrida	v. Ma	nukand		
Ball	permit Depart Impor eny in		21. Signature of Funeral Service Li	censee D.	101 b	22.7	ame and Addre	ss of Facilit	11/4/2006 Schimunek	Funeral	Home	S		
			23a. Part1. Enter the disease, or c	omplications that cau	ised the death. Do r	970	the mode of dyir	<u>た Rd。</u> ng, such as	, Baltimor cardiac or respiratory	e, MD 21 arrest,	236	Approximate		
	Physician		shock, or heart failure. List of Immediate Cause (Final disease or condition	-	ture L	120	Few					Interval Between Onset and Death		
	/Medical Examiner		resulting in death)		as a consequence	of):	16.							
	Cxammer	Į.	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a consequence	of).								
	uted d ansit	Examiner	cause. Enter Underlying Lause Disease or Injury that initiated events c.											
oʻ	ate be executed thysician and the burial-transit	Еха	resulting in death) Last	c Due to (or	as a consequence	of):								
8760,	ate be hysici the bu	dicai	d											
9	the death certificate be executed y the attending physician and tched for use as the burial-transit	/Mec	IF FEMALE:	23c. If yes, outco	me of pregnancy					201 0				
Box	death e atter d for u	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No	1 ☐Live birth	h 2 Fetal death nt at time of death		ctopic pregnancy Other (s <i>pecify</i>)	1			ite of deliver onth	ny Day Year		
P.0	that the ded by the destached	hys	9 Unknown	9∐ Unknow										
	ogu ec	by	Part II. Other significant condition	s contributing to deat	th but not resulting in	the unde	erlying cause giv	en in Part I.		_		e cause of death?		
Records,	w require been si should t	Completed							-	Yes 2 □ No	3 Proba	ably 4 Onknown		
Rec	he taw s has l ge 2 s	ldmo								psy		sy findings available appletion of cause of		
Vital		ø	25. Was case referred to medical					26 Place	of Death (Check only	2 No	1 🗆 Yes	2XNo		
		To B	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inp	oatient 2 ER/Ou	tpatient	3 DOA Oth	10.55	rsing Home 5 Res		ner (Specify)		
0 0	ding Ph h. After th funeral		27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of (Month,		ime of	28c. Injur Wor	y at k?	28d. Describe	how injury occur				
Division of	death death ctor: /	icat	2 Accident investiga 3 Suicide 6 Could no	ot be	17,2006 UM		N	Yes 2		(Street and Numl	an or Oun!	Route Alumber		
27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury 28b. Time of Injury at Work?									City of 16	Wn, State) 50	96 7	סאלה אק		
	To the Hospital or Attendin within 24 hours after death. To the Funerel Director: Aft completely filled in by the fur	edical C	29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the be	est of my knowledge	, death or	ccurred at the tir	ne, date an	d place, and due to the	cause(s) and ma	anner as sta	206 ated.		
	To the H within 24 To the Fi	Medi	0.10)	and manner	r stated.	201 111463			in occurred at the time					
	S S S S		29b. Signature and title of certifier	T AM.	100		29c. Licens		7	29d. Date signe				
ıÌ	V		o. ame and address of person w	no completed cause	of deat (Item 2-a)	Type, Pri	int)	906	7 : Luther v:1	1000em	ב מעפ	2006		
1	J		Philip Mili	tello, M	D 6 Tr	يا س	if Halo	II CT	Luthervil	Le Ma	12	092		
	Sta Registr		31. Date filed (Manth, Day, Year) NOV 0 8 20	06 32. Reg	jistrar's Signature		الريا							

			1 - For State Registrar	State of Ma	ryland	/ Depa	artmen <i>tificat</i>	t of H e of L	ealth a Death	and M		giene Reg. No.	200	6 3	5353
	Physici /Medic		1. Decedent's Name (First, Middle, Las	:1)				000	od An	rel	2. Date of Dea Month	Day	31 Z	3. Tim	e of Death
	Examin		4a Facility Name (If not institution, given 5. Social Security Number 6. S	Kins He	OSP 14 (In yrs. las	t birthday)	4b City, DA If Under Months	Hir	Location of MOR	5	8. Date of Birt	4c. County of Death Md . rth ay, Year) 9. Birthplace (State Country)			ite or Foreign
	Director		217-74-9698 ¹ Usual Residence of Decedent	⊠ M 2□F	46	Yrs.		Days	Hours	Willi.	8–25-	-60	0′ Md.		
	death with the Maryland me 23a or 28e-f ehow f.m.tat be rediffed at	tor	Md. 10b. County	1	10c. City, 1	Town or Lo Balt	cation imore	e					10d. Inside City Limits		
	or 28	Director	10e. Street and Number				10f. Zip					10g. Citi	zen of What	Country?	
	eath v	erai	449 N. Milton A	Ve . 12. Was Decedent E	ver in II S	12.1	Mas Dagge	212		nin? /Coo	oifu Vac or No		USA	merican India	-
0	ter e	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:			f Yes, spec		Specify:	, Puerto	ecify Yes or No- Rican, etc.)		Black, White, etc. Specify: Black		
7-C17-I	be filed within 72 hours after at Hygiene. I other then "naturel", or ite yeent, the Munical Examina	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5+		life. L	kind of wo DO NOT us	rk done o	lurina most	of worki	ng		nd of Busine	ss/Industry	
7	filed v Hygie Sther 1	Be Co	11th grade 17. Father's Name (First, Middle, Last)	· · · · · · · · · · · · · · · · · · ·		Coo	K		18. Mothe	r's Name	(First, Middle,		Chef		
y a	2 should be f and Mental h is marked of reumatic eve	To B	William 19a. tnformant's Name/Relationship (odard		a Address	(Street a		arth		. Cib. o	Sawyer City or Town, State, Zip Code)		
, Mar	and 2 salth an n 27 le i		Gloria G. Woodar				-				altimore				
aitimore	Pages 1 nent of He nnt: If iter iry or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Dopation 5 ☐ Other (Specify		cem	e of Disponetery, crem	natory or o	ther place	9))ate			or Town, Stat	
Salt	permit. Pages Department of I importent: If its eny injury or o		21. Signature of Funeral Service Licen				. Name an	d Addres	s of Facility	у	1-9-06 March	F.H	. East	_	
	un e u	.,	23a. Part). Enter the disease, or come shook, or heart failure. List only	plications that caused	he death.						, Baltin or respiratory ar		, Ma.	21202 Approxi	mate
ı	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a		Tempor	nach							Onset a	Between and Death
	Examiner		Sequentially list conditions	b. Deno	ca. 01.0	1 60								timo	neeks
7	ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequer		place	cat						one.	onth
6/00,	death certiticate be executed e attending physician and of for use as the burial-transit	dicai Exa	resulting in death) Last	consequer	nsequence of):								1-00	21100	
X OX	sertiticat ding phy se as th	/Medi	IF FEMALE:	23c. If yes, outcome o	of pregnance	A/									
)	the death of the attention ached for un	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	2 ☐ Fetal de	eath 3	Ectopic pr Other (sp					2	23d. Date of Month	delivery Day	Year
ras, r	law requires that as been signed b 2 should be deta	5	Part II. Other significant conditions of	ontributing to death but	t not resulti	ng in the ur	nderlying c	ause give	en in Part I.			bacco u es 2[to the cause Probably 4	
ř	The ate ha page	Completed									24a. Was autop	sy med?	prior death	autopsy findii to completion ?	ngs available of cause of
VII all	cien: ertific actor,	Be	25. Was case referred to medical examiner?							of Death	(Check only o				
6	Physi this c al din	2	1 Yes 2 No	Hospital:		VOutpatien			4 🗀 IVU		me 5 Resid			pecify)	
0	Attending Physicien: r death. ector: After this certitic by the funeral director.	tlon	1 Naturat 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	Year)	8b. Time of Injury	M	8c. Injury Work	rat ⊲? ∕es 2∐1		28d. Describe h	iow infun	y occurred		
DIVISION	To the Hospital or Attending Physicien: within 24 hours atter death. To the Funerel Director: After this certific completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be determined	28e. Ptace of Injur building, etc.	ry - At home (Specify)	e, farm, stre	eet, factory	, office			28f. Location (S City or Tow	itreet and m, State	d Number or)	Rural Route I	Vumber,
	Hospit Z4 hour Funer letely fills	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of niner: On the basis of and manner stat	examination	edge, death n and/or inv	occurred vestigation	at the tim , in my op	e, date and pinion, deat	d place, a	and due to the ded at the time, d	ause(s) date and	and manner place, and o	as stated. due to the caus	se(s)
)	To th withir To th comp	Me	29b. Signature and title of certifier	1 2	isicle-	t		License	number				e signed (Mo	onth, Day, Yea	r)
	m		30. Name and address of person who	completed cause of de	ath (Item 2	3a) (Type,	Print)	LA	111	. 10	15 111	0.1	2.1	2000	1
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar	r's Signatur	10 (F	8 3	- 10	1414	IMU,	ea, MA	241	4144	J138_	/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. U U 6 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month 11 BETTY 2006 WALKER 04 9:00a^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** ROSEDALE 822 ROSEDALE AVENUE BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8/04/1930 Birthplace (State or Foreign Country)
 VA 5. Social Security Number **Funeral** 226 34 1 M 2 SF 76 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene.
ant: if Item 27 is marked other then "neturel", or Items 23a or 28e-f show try or other traumatic event, the Musical Experiment the multibe multified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MA 1 ☐ Yes 2 No Director ROSEDALE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 822 ROSEDALE AVENUE 21237 Funerai 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 22 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Š WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be UNKNOWN ဥ THOMPSON UNKNOWN **UNKNOWN** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 822 ROSEDALE AVE., ROSEDALE, FILMORE T. WALKER/HUSBAND MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 11/06/2006 BALTIMORE, 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Fund ice Vicensee 1211 CHESACO AVE., ROSEDALE, MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** untricular disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner pertendion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or a a consequence of): Examine The law requires that the death certificate be executed attending physician a I for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medlcal IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐ Yes 2 No 9 Unknown 9 Ulnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 ANatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) 4 🗌 Homicide within 24 hours a To the Funerel [1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00029197 30. Name and address of person ted cause of death (Item 23a) (Type, Print) M. NICHE GIOI FRANKLIN SQUARE OR BALTO 31. Date filed (Month, Day, Year) State NOV 0 8 Registrar

			1- State of Maryland / Dep	partment of Health and Mertificate of Death	ental Hygier Reg. I	2006 35355		
			Decedent's Name (First, Middle, Last)		2. Date of Death Month	3. Time of Death		
П	Physici: /Medic		J. Benjamin Williams		November	1, 2006 10:07 PM		
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death		
			Holy Cross Hospital	Silver Spring		Montgomery		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) 1 ☑ M 2 ☐ F 93 Yrs.	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)		
	Director		404-12-0769 Yrs. Usual Residence of Decedent		December 8,	1912 Missouri		
	and wc		10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits		
	Mary -f eh	ţ	Maryland Montgomery Silver	Spring		1 ☐ Yes 2 🖾 No		
	r 28a	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?		
	h with	O E	2800 Elnora Street	20902		United States		
	deat	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13 Armed Forces?	B. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F	cify Yes or No-	14. Race - American Indian, Black, White, etc.		
9	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f ehow fra Medical Examinat must be notified at	臣	1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Never Sive	1 ☐ Yes 2 ☑ No Specify:	nouri, oto.)	Specify: White		
8	Jrai',	d by	3 Wildowed 4 Divorced Year or Dates: War II			WII 2 C C		
<u>7</u>	nati	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation re kind of work done during most of workir DO NOT use retired)	16b.	. Kind of Business/Industry		
7	withir ane. than	m	Elementary/Secondary (0-12) College (1-4or 5+)	Rose Breeder		Horticulture		
D	Hygie Hygie ther		17. Father's Name (First, Middle, Last)		(First, Middle, Maid			
an	d be antal	To Be	Benjamin Grant Williams		tha Allen			
Maryland 21215-0036	shoul nd Me mark	Ĕ	19a. Informant's Name/Relationship (Type, Print) 19b. Ma	iling Address (Street and Number or Rura	l Route Number, Cit	y or Town, State, Zip Code)		
Š	nd 2 aith a 27 is r trai		Benjamin R. Williams / Son 2800) Elnora Street, Si	lver Spri	ng, Maryland 20902		
ē,	of Hei		20a. Method of Disposition 20b. Place of Dis	position (Name of Position (Name of Novem	ate 20c. ber	Location - City or Town, State		
Ë	Page nent c int: If		4 Donation 5 Other (Specify)	wn Memoral	006 R	ockville, Maryland		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heatih and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-1 ehow any injury or other traumatic avent, it a Medical Examinat must be notified at once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Roh	ert A. Pu	mphrey Funeral Home/ 557 Wisconsin Avenue		
<u> </u>	8 9 ₹ 9		M01433	Bethesda, Maryland	20814	JJ/ WISCONSIN AVERGE		
			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or	r respiratory arrest,	Approximate Interval Between Onset and Death		
ı	Pnysician		Immediate Cause (Final Atherosclerotic	isease	Onset and Death			
	/Medical Examiner		resulting in death) Due to (or as a consequence of):					
	Lxammer		Sequentially list conditions, b. Use to for as a consequence of).					
	By V E	Jine	ally, leading to minediate cause. Enter Underlying Cause (Disease or injury					
•	and and	xan	that initiated events c. Due to (or as a consequence of):					
8760,	icate be executed physician and s the burial-transit	dical Examiner	4					
687	tificate ng phys as the	edic	U.			1		
Box	eath certifi attending r	M	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery		
	death certific e attending p id for use as	icia	in the past 12 months? 1 Ves 2 No. 1 Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)		Month Day Year		
P. 0.	that the de ned by the a detached f	hys	9 ☐ Unknown					
S,	requires that the	by Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	to use contribute to the cause of death?		
2d	w require been si should l	ted	Hypertension		1 🗌 Yes	2 No 3 Probably 4 ⊠Unknown		
of Vital Record	aw 2 s b	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of		
<u> </u>	The ate has page	FO.			performed 1 ☐ Yes 2 ☑	? death? _		
/ita	cian: ertific ector.	Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)			
_	Physician: this certificantal director.	2	1 ☐ Yes 2 ☒ No Hospital: 1 ☐ Inpatient 2 ☒ EP/Outpati 27. Manner of Death 28a. Date of Injury 28b. Time			6 □Other (Specify)		
	Jing After fune	lo	1 ☑ Natural 5 ☐ Pending (Month, Day Year) Injury		8d. Describe how in	ijury occurred		
<u>:</u>	deat deat ctor:	ical	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury: At home, farm, s		Rf. Location (Street	and Number or Rural Route Number.		
Division	spitel or Attenous effer deatlerel Diractor:	Certification:	4 Homicide determined building, etc. (Specify)	stroot, radiary, amou	City or Town, St.			
	To the Hospitel or A within 24 hours effer To the Funerel Dirac completely filled in by		29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge, de	ath occurred at the time, date and place, a	and due to the cause	e(s) and manner as stated.		
	To the Hos within 24 h To the Fun completely	edical	(Check only one) 2 Medicaf Examinar: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurre	ed at the time, date a	and place, and due to the cause(s)		
	To the within To the Comp	Ž	29b. Signature and title of certifier	29c. License number	29d. I	Date signed (Month, Day, Year)		
)	χÌ		1 / an M.	D41624		11/2/2006		
	2001		30. Name and address of person who completed cause of death (Item 23a) (Typ		0	11 00010 1/0/		
	5		1 3	Glen Road, Silver	spring, M	aryland 20910-1484		
	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 8 2006 32. Red strar's Signature	Speaker				
	3	الرو						

		1 - For State Registrar		epartment of Health and Certificate of Death		400b 3335b		
Physic	cian	Decedent's Name (First, Middle, La	st)	oranoato or boarn	Reg. N 2. Date of Death Month D	3. Time of Death		
/Med Exam	lical	4a. Facility Name (If not institution, give	William S re street and number)	4b. City, Town, or Location of Dea	November e	6 2006 01:00 PM		
		Sinai Hospitas 5. Social Security Number 6.5		Balhmore (day) If Under 1 Year If Under 24 Hi	Cify s. 8. Date of Birth	NA		
Funera Directo		215-60-7208	10	Months Dave Hours Mir		9 Birthplace (State or Foreign Sountry) Maryland		
inyland ihow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	or Location	/	10d. Inside City Limits		
the Ma	recto	Maryland NJ7 10e. Street and Number		Battimore 10t. Zip Code	10a C	1 1 1 No es 2 □ No citizen of What Country?		
1215-0036 within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f ahow he Maryleal Executar trivial to cotified at	Funeral Director	6968 Glerhe	ights Rd.	21215		USA		
after de or Item	Fune	11. Marital Status 1 Never Married 2 Married	M2. Was Decedent Ever TU.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give	13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 1 Yes 2 No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc.		
5-003	ted by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's E	Year or Dates: ducation 16a. D	ecedent's Usual Occupation	16b.	Specify: DIACK Kind of Business/Industry		
1215 within 7 ane. then 'n	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	Give kind of work done during most of wife. DO NOT use retired)	orking	rood Stace		
N 0 0 -	Be	17. Father's Name (First, Middle, Last,		18. Mother's Na	ame (First, Middle, Maide	n Sumame)		
Maryland d 2 should be file th and Mental Hy IT Is marked oth traumatic avant	²	Eddie Willi 19a. Informant's Name/Relationship (Type, Print) 19b. N	Aailing Address (Street and Number or F	Ola DWN Rural Route Number, City	or fown. State. Zip Code) 21215		
B, Ma 1 and 2 1 ealth a 1 ealth a 1 ealth a 1 ealth a		Eleanor Wi	llians 6	968 Glenheight	s Rd. Ba	Himory Maryland		
altimore, rmit. Pages 1 ar partment of Hea portant: If Item: y Injury or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State cemetery,	isposition (Name of crematory pother place)	Indole Wa	Location - City or Town, State Marian		
Baltimo permit. Page: Department or Important: If i any injury or		21. Signature of Furieral Service Lice	Darvin	22. Name and Address of Facility	when Funer	altone PA 21209		
s s a		23a. Part1. Enter the sizease, or com shock, or heart failure. List only	plications that caused the death. Do not one cause on each line.	enter the mode of dying, such as cardia	ac or respiratory arrest,	Approximate Interval Between		
Physician /Medica		tmmediate Cause (Finat disease or condition resulting in death)	a. Cuebe	ellar bleed		Onset and Death		
Examiner		Sequentially list conditions,	b. Due to (or as a consequence of)	tension		lo years		
uted	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of)	:				
Hecords, P.O. Box 68760, The law requires that the death certificate be executed the has been signed by the ettending physicien and bage 2 should be detached for use as the burial-transit		resulting in death) Last	Due to (or as a consequence of)					
rtificate ng phys	Medical	IF FEMALE:	d					
Box 6 leath certificether of tending part of the use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 ☐Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year		
IS, P.O. I	Physi	9 Unknown	9□ Unknown					
COTCS, w requires the been signers should be designers.	þ	Part II. Other significent conditions of	ontributing to death but not resulting in th	ne underlying cause given in Part I.		use contribute to the cause of death?		
VItal Hecords, stcien: The law requires to certificate has been signe rector, page 2 should be o	Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of		
	a	25. Was case referred to medical		26 Place of Da	performed? 1 ☐ Yes 2 ☑ No	death?		
	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☑Inpatient 2 ☐ ER/Outpa	Debara	eath (Check only one) Home 5 Residence	6 ☐Other (Specify)		
ISION O Itending Ph death. Itor: After th the funeral		27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Tim	e of 28c. Injury at	28d. Describe how inju			
DIVISION OF I or Attending Physatter death. Director: After this in by the funeral d	Certification:	3 Suicide 6 Could not be 4 Homicide determined	1		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
ppita ours neral		29a. Certifier 1 Certifying Ph	ysician: To the best of my knowledge, d	eath occurred at the time, date and place	e, and due to the cause(s	s) and manner as stated.		
the Hos hin 24 h the Fur mpletely	Aedical	one)	niner: On the basis of examination and/o and manner stated.	investigation, in my opinion, death occ	surred at the time, date an	d place, and due to the cause(s)		
To With	Σ	29b. Signature and title of certifier ASSAR You	PUSSEF MD	29c. License number RES - 00		ate signed (Month, Day, Year)		
61		30. Name and address of person who	completed cause of death (Item 23a) (Ty	pe, Print)	to soite 0	vember 6, 2006 + Balfimore		
St	ate	31. Date filed (Month, Day, Year)		The since t	10 3/1/100	1 Day rimore		

Pahint Moun as Percell Williams

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

Bobbie Dean Wal		I- For State	Sta	te of Maryl			nt of Hea		Mental Hy	ygiene	,	200	0000
Physician		Registrar 1. Decedent's Name (F	First Middle	.ast)		erincai	e or bea			2. Date of Dea	eg No. 🔏	200	3. Time of Death
Physician Medical Examin		Bobbie I								Month Novembe		Year	1727 hrs
(4a. Facility Name (if no 5004 59th Ave		give street and n	umber)			, Town, or L ttsville	ocation of Death			inty of Death e George	
Funeral	7	5. Social Security Num	nber 6	. Sex	7. Age (In y	rs last birthd		ider 1 Year	If Under 24Hrs.		th(MM/DD/Y	YYY) 9. Birl Foreig	thplace (State or
Director		431-94-97	29	M 2X F	5.5	5	Yrs. Mon	ths Days	Hours Min.	March	ı 11,	1950	untry) AR
· ·	- 1	Usual Residence of De	ecedent b. County		I10c (City, Town or	Location						10d. Inside City Limits
liow any	- 1			George		attsv							1 Yes 2 X No
aryland 8a-f st	Director	10e. Street and Number		George	1115	accsv.		ip Code		1	0g. Citizen o	f What Cour	ntry?
ith the Maryland 23a or 28a-f show notified at once.	<u>=</u>	5004 59	vh Str	eet			20	0781			Ţ	JSA	
h with	Funeral	11 Marital Status 1 X Never Married		12. Was De	cedent Ever i	n U.S. 1			panic Origin? (Sp Mexican, Puerto			Race - Ameri Vhite, etc.	can Indian, Black,
er deatl	티			1 Yes	2 X N		1 Yes			lack		sify: Bla	ok.
urs afte	출	3 Widowed 15. Decedent's Educ		or Dates:		d) 16a. De	cedent's Usu	al Occupation	on (Give kind of w	vork done		of Business/l	
72 hound in "mate	탈	Elementary/Second	lary (0-12)	College	(1-4 or 5+)	du	ring most of w	rorking life	DO NOT use retir	red)			
)036 within iene. er tha	Completed	12		<u> </u>		Hor	nemake		211111111111	(C' Baidelle		ome	
21215-0036 uld be filed within 7 Mental Hygiene marked other than ever, the Medica		17. Father's Name (Fin							8.Mother's Name Beatric			ame)	
212 ould be ould be I Ment is mark	To Be	William 19a. Informant's Name			·-	19b. I	Mailing Addre	ss (Street	and Number or F			Town, State	, Zip Code)
MD and 2 should and and 27 is		Leacer Wa	<u>lker -</u>	Daughte	er				e. Hyatt	sville,		0781 ion - City or	Town Chata
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Dispos 1 Burial 2 X		3 Removal			Disposition (N y or other plac					,	
Baltimer Permit. Pag Department Important:	4	4 Donation 5			1	Metro (Cremate	ory	of Facility	·. 8, 06	Balti	more,	MD
Bal permi Depa Impo		KIM	Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 2122									28	
Physician	1	23a Part I. Enter the of failure. List only			caused the de	eath. Do not e	enter the mod	e of dying, s	such as cardiac o	r respiratory arr	est, shock, o	r heart	Approximate Interval Between Onset and
/Medical xaminer	1	Immediate Cause (Fir or condition resulting	nal disease	a. Hypert	ensive (ascular	disease	e				Death
V	-	Sequentially list condi		Due to (or as	a consequen	ce of):							
	ine	if any, leading to imme cause. Enter Underly	ediate ring Cause	Due to (or as	a consequen	ce of):							
nsit Ap	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):											
	edical	X UNPENDED AMENDED #23a, PII, 27, perME, G861, 11/14/06 TT											
760, icate by physicate but the business in th		IF FEMALE: 23b. Was decedent pre	egnant in the	23c. If yes	outcome of	oregnancy		. [te of delivery	
, P.O. Box 6876 rres that the death certificat signed by the attending phile detached for use as the	Physician/M	past 12 months?		4 Preg	birth nant at time o	2 L of death 5	Fetal deal		Ectopic pregna	ancy	Mont	ın L)ay Year
Boy e death the att	hysi	1 Yes 2 No		a Clik	nown					lee Pili			C leading
b.O. that the thought detach		Part II. Other signific		ns contributing ia, obesit		not resulting i	n the underly	ing cause gi	iven in Part I		_		the cause of death?
ords, I	Completed by	AMOILL	KIL IICI.II	ia, oksit	- <u>y</u>					24a Was			topsy findings available
COL	힕										rmed?	death?	completion of cause of
l Rec	ပ္ပို	25. Was case referred	d to medical					26 Place	of Death (Check	1 Yes	2 No	1 🗸 Ye	es 2 No
Vita vysician his cer direct	밁	examiner? 1 ✓ Yes 2	_	Hospital: 1	Inpatient 2	ER/Out	patient 3	DOA	Other Nursin	ng Home 5	Residence	6 🗸 Other	r: Scene
n of Jing Ph After t	إيّا	27. Manner of Death			e of Injury th, Day,Year)	28b. Tır	me of Injury		y at Work?	28d. Describe	how injury oc	curred	
Sior Attend death death softor:	ij	2 Accident	5 Pendir Invest	gation	ace of Injury -	At home, form	n etroat facts		es 2 No	28f Location /	Street and No	umber or Pi	ral Route Number, City
Division pital or Attend tours after death. eral Director: filled in by the f	Certification	3 Suicide 6	6 Could detern	not be		At nome, ran	n, sireer, racio	ny, omce be	anding, etc.	or Town,		aniber of re	nai Nodio Nambori, Oky
e Hospi n 24 hou e Funer letely fil		29a. Certifier 1 Ce		sician: To the b									
To the P within 2.	Medical			iner:On the basi and manner		on and/or inv				at the time, date			
	≥	29b. Signature and tit	ie of certifier	da	00	0 .		29c License O.C.N				signed <i>(M</i> oi ber 6, 200	nth, Day, Year)
		30 Name and address	is of person v	yho completed ca	use of death	(Item 23a)							
		Carol Allan, M	ne and address of person who completed cause of death (Item 23a) rol Allan, MD — Assistant Medical Examiner — 111 Penn Street, Baltimore, MD 21201										
Sta Regist		31. Date filed (Month, NOV	Day, Year) 2	006 32	Registrar's Sig	nature	Conte	,					
rtegist													

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 2001 James R. Woodard /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospita Franklin ROS edale If Under 1 Year | If Under 24 Hrs. 59 Mare TIMOI 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours Min. 1**X**M 2□F Days 5-5-1936 Director 242-50-9779 70 NC Usual Residence of Decedent 10a. State 10c. City, Town or Location *ohe 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "naturel", or items 23s or 28s-1 show any injury or other treumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director MD Essex Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2207 Corsica Road 21221 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married ODdord JomeS imore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No ģ Specify: 3 Nwidowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Paint Inspector General Motors 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Milton Woodard Ethel I. Little 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 2 2 1 MD 19a. Informant's Name/Relationship (Type, Print) 1000 Franklin Avenue, Apt. 1207, Esséx, Gary Woodard - Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Bayview Crematory 11-10-06 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Bradley-Ashton Funeral Home, 21. Signature of Euneral Service Ligensee PA, 2134 Willow Spring Road, 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Anoxia Physician /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physicien and the burial-transit Division of Vital Records, P.O. Box 68760 Physician/Medical use as IF FFMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy ğ in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐ Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? **全** cate has been sign, page 2 should be 2 No 3 ☐ Probably 4 ☐ Unknown 1 Z Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🗷 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification; 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending М 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital within 24 hours a To the Funerel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Mydical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 11/6/06 D0054725 on Klin Square Drive Baltimore 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 M.Jase LoPez 31. Date liled (Month, Day, Year) State NOV 0 8 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 006 . Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 2006 7:04am^M White Nov. 4 Elise /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Nursing Center Towson
If Under 1 Year Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 28, 1931 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1□ M 2√2 F 75 Yrs Director 213-30-7535 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifiled at 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 ☐ No **Funeral Director** N/A Baltimore MD 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? U.S.A. 845 N. Milton Ave. 21205 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Black Completed by 3 □ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9th Housewife Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ Isaac Taylor Addie Elliott 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward White/husband 845 N. Milton Ave. Balto. MD 21205 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Trinity Cemetery Nov9,2006 Baltimore, Md 22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME
1412 E. PRESTON ST. BALTO. MD 21. Signature of Funeral Service Licenses Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused it shock, or heart failure. List only one cause on each line death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-trans Due to (or as a consequence of) Physician/Medical attending ph for use as t IF FEMALE: If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Vear 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the sahould be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a Wasan certificate has b 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Sother (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation in 24 hours after or the Funeral Director: After the Funeral Director: After the funeral of the 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifiei Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NOVTh Charles ST. Suite 209, Parson 212041 65 32. Registar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

NOV 0 8 20d6

			For State Registrar	tate of Maryland	•	t of Health and M e <i>of Death</i>	lental Hygie Reg.	ZUUh	35360
			Decedent's Name (First, Middle, Last)	1.	00111110011		2. Date of Death	Day Year	3. Time of Death
	Physici: /Medic		MagdAlene	young			Nov	1 2006	12: 10 pm
	Examin	er	4a. Facility Name (If not institution, give street ST AGNES Hos			Fown, or Location of Death		4c. County of Death	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. In	est birthday) If Under	1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	9. Birtho	place (State or Foreign
	Director		337-52-5968 10M	20 F 74	Yrs. Months	Days Hours Min.	3-11-10	932 M	reyland
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Location		**	1	Od. Inside City Limits
	death with the Maryland ms 23s or 28s-1 show	to	MD		Ballimon	2e			1 Yes 2 □ No
	or 28s	Funeral Director	10e. Street and Number	1.04	10f. Zip		10g.	Citizen of What Cour	ntry?
	s 23s	rail	()	nea Avenue		21317		14. Race - Americ	and ladice
(0	fter de	Fune	1 ☐ Never Married 2 ☐ Married	Nas Decedent Ever in U.S Armed Forces? I □Yes 2 ☑ No		ent of Hispanic Origin? (Sp ify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	
21215-0036	ral', o	þ	3 Widowed 4 Divorced	f Yes, Give Year or Dates:	1 ☐ Yes 2	2010 Specify:		Specify: 13L	ack
15-6	"natu	Completed	15. Decedent's Education (Specify only highest grade co	nn mpleted)	16a. Decedent's Usua (Give kind of wor life. DO NOT us	k done during most of work	ing 16t	. Kind of Business/In	
212	withigh within them them	ошо	Elementary/Secondary (0-12)	College (1-4or 5+)	Private		rse	NURSING	
P P	al Hyg	Bec	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle, Mai	den Sumame)	
yla	ould b	2	Sessie Bari	4		1=54e	IIA /ag	ILOR	4 . 4 3
Maryland	d 2 sh th and 17 ie m treum		19a. Informant's Name/Relationship (Type, DESIREE Thom	ESRand ++	19b. Mailing Address	(Street and Number or Run	al Route Number, Ci	ity or Town, State, Zip	Code)20/20
	s 1 an f Heel item 2 other	3	20a. Method of Disposition	20b. Pi	ace of Disposition (Namerelegy, crematory or of	ne of ther place)	Date 200	Location - City or To	own/State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heelth and Mental Hygiene. Importent: if Item 27 ie marked other then "natural", or Items 23a or 28a-1 shov any injury or other treumatic event, the Medical Evantinar must be notified at 2008.		1 ☐ Burial ☐ ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	oval from State M+	Zion Ceme	Yery 11/7	106 1	ballo. Mo	1 1 11
3alt	permit. Departr Importr Import		21. Signature of Funer I Service Licensee	1. 0	22. Name and	d Address of Facility	el's mert	politica Ch	afective.
	40.2 * 4	1 6	23a. Part 1. 5 Near the disease, or complicati shock or heart failure. List only one complications	ons that caused the death	Do not enter the mode	O IBROACULE e of dving, such as cardiao	or respiratory arrest.	Ma. 213	Approximate
	Physician		Immediate Cause (Final)- 0 0			,,		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequ		ILURE			On Known
	Examiner		Sequentially list conditions, b. —	METASTA.		EAST CAR	2CI NOM	A C	inknown.
	De la la la la la la la la la la la la la	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	ence or _i :				
ó	execute on and rial-tran		resulting in death) Last	Due to (or as a consequ	ence of):				
8760,	physicien and	dical	d						
9	n certific anding p use as:	/Mec	IF FEMALE: 23c.	f yes, outcome of pregnar	ncv			23d. Date of delive	
, g	death e etter d for u	Iclar	in the past 12 months?	1 ☐Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3 Ectopic pro			Month	Day Year
Magdalene Vital Records, P.O. Box	Physicien: The law requires that the death certifit this certificate has been signed by the ettending ral director, page 2 should be detached for use as	by Physician/Me	9 □ Unknown	9□ Unknown					
A ls,	res th signed I be de	by	Part II. Other significant conditions contrib	uting to death but not resu	lting in the underlying ca	ause given in Part I.	23e. Did tobac 1 ☐ Yes	co use contribute to th 2 □ No 3 □ Prob	
Sor de	v requ	Completed		CATIV		····	24a. Was an		psy findings available
λa Re	he lav e has age 2	dmo	- CARDIONY	VA I H]			autopsy performed	prior to condeath?	mpletion of cause of
ital	sicien: The lav certificate has rector, page 2	BeC	25. Was case referred to medical examiner?			26. Place of Deat	1 ☐ Yes 2 ☐ h (Check only one)	no lu tes	20 100
00	Physic this ce al dire	10	1 ☐ Yes 2 ☑ No Hosp	1 ⊠ Inpatient 2 ⊔ I	R/Outpatient 3 DO				y)
SUP on o	en en	tion	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	8a. Date of Injury (Month, Day Year)	28b. Time of 2. Injury M	8c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how i	njury occurred	
Division	Attending at death. ector: After by the fune	Certification; To	2 Suisite 6 Could not be	8e. Place of Injury - At ho building, etc. (Specify	me, farm, street, factory	, office	28f. Location (Stree City or Town, S	t and Number or Rura	i Route Number,
۵	oitel or ars aft rei Di				<u> </u>				
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Medical	29a. Certifier 1 VCertifying Physicia (Check only one) 2 Medical Examiner:	In: To the best of my know On the basis of examinat and manner stated.	vledge, death occurred a ion and/or investigation,	at the time, date and place, in my opinion, death occurr	and due to the caus red at the time, date	e(s) and manner as si and place, and due to	tated. o the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier		()	License number	1	Date signed (Month,	Day, Year)
			1 thung		12 C	2002000	No	مل الم عد	006.
	1		30. Name and address of person who comp	eted cause of death (Item		BALTIMOR	E MO 21	229.	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signat			01,		
	Registi		107 0 8 2006	Bene D	(Cooks				
Di	HMH 17 Rev 1/2	001			ORIGINAL				
					UnidiNAL				

		State of Maryland / Department of Health and I 1- State Registrar Certificate of Death		giene 00	5 35361
Physic	ian	Decedent's Name (First, Middle, Last) Byung Ha Yi	2. Date of Dea Month	Day NY Ye	a. Time of Death
/Medi Exami		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Bo, Himura Winhington Medical Control Wien B	1	4c. County of D	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 80 Yrs. Months Days Hours Min.			Birthplace (State or Foreign Country) Korea
		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	111111111111111111111111111111111111111	1,20	
e Maryla a-f ehov	ctor	MD Anne Arundel Hanover			10d. Inside City Limits 1 ☐ Yes 2 → No
th with the	al Director	10e. Street and Number 1143 Stoney Run Road 21076		10g. Citizen of Wha USA	Country?
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-1 show any Injury or other treumatic event, tra Medical Espain errout for notified at once.	by Funeral	11. Marital Status 1 Never Married	pecify Yes or No- o Rican, etc.)	14. Race - / Black, V Specify:	American Indian, Vhite, etc.
Baltimore, Maryland 21215-0036 sernit. Pages I and 2 should be filed within 72 hours atl Depertment of Health and Mental Hygiene. myoritani: If them 27 is marked other than "naturel", or my fourty or other treumatic event, tre Medical Errori 2028.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	king	16b. Kind of Busin	ess/Industry
d 21 filled wi wher th	Co	12 Farmer 17. Father's Name (First, Middle, Last) 18. Mother's Name	ne (First, Middle,	Self Emp	Loyed
ylane	To Be	Pyung Yi Sun He	ee Chung		
y Mar and 2 st salth and n 27 le n		Pok Ki Eddy/Daughter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru 1143 Stoney Run Rd Ha			te, Zip Code)
TOOLE		20a. Method of Disposition 1 Burial 2 XI Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetary, crematory or other place) Metro Crematory, Inc 11/4/	Date /06	20c. Location - City Baltimore	
Baltin permit. P Depertmin Importan Imy Injur					
		21. Signature of Funeral Service Ucansee Todd Dring 22. Name and Address of Facility Cremation Society 299 Frederick Rd F 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	Baltimor or respiratory ar	e, MĎ 212 rest,	Approximate Interval Between
Physician /Medical		disease or condition resulting in death)	mhany	Disens	Onset and Death
Examiner	L	Due to (or as a consequence of): Sequentially list conditions, b. Due to (or as a consequence of):			
ecuted and and and	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):			
8760, cate be executed physicien and €		d			
Records, P.O. Box 68760, The law requires that the death certificate be executed the has been signed by the ettending physicien and K.	hysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of Month	delivery Day Year
ds, P	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to		e Io the cause of death? Probably 4 □Unknown
Record le law requir has been si	ompleted		24a. Was autop	sy prior	a autopsy findings available to completion of cause of
	O	25. Was case referred to medical 26. Place of Dea		2 No 1 🗆	
Of V Physici this ce	To B	examiner/ 1 Yes 25 No Hospital:	ome 5 Resid	ence 6 Other (Specify)
ision (tending for death.	atlon	27. Mapner of Death TNaturat 5 Pending (Month, Day Year) 28a. Date of Injury 28b. Time of Injury Work? 2 Accident investigation 28a. Date of Injury 28b. Time of Injury Work? 1 Yes 2 No	28d. Describe n	ow injury occurred	
Division or Attending after death.	ertification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow	Street and Number o	r Rural Route Number,
Division of Vita Division of Vita To the Hospital or Attending Physician: within 24 hours after death. To the Funaral Director: Alier this certific completely filled in by the funeral director,	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examiner: On the basis of my knowledge, death occurred at the time, date and place 2 medical Examiner: On the basis of my knowledge, death occurred at the time, date and place 2 medical Examiner: On the basis of my knowledge, death occurred at the time, date and place 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examiner: On the basis of examination and on the basis of examination and on the basis of examination and other and the basis of examination and other and the basis of examination and other and the basis of examination and other and the basis of examination and other and the basis of examination and other and the basis of examination and other and the basis of examination and other and the basis of examination and other and the basis of examination and other and the basis of examination and other and the basis of examination and other and the basis of examination and other and the basis of examination and other and the basis of examination and other and the basis of examination and other and the basis of examination and othe	, and due to the or rred at the time, o	cause(s) and manne date and place, and	r as stated. due to the cause(s)
To the within To the comple	Me	29b. Signature and title of certifier 29c. License number	1	29d Date signed (M	onth, Day, Year)
9		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1	11042	V 6
St	ate	31. Date filed (Month, Day, Year) 8 2006 32. Registrar's Signature	Dr.1	4 my	an, Himm
Regist	rar	NOV 0'8 2006			

06-08316 Rudolph Alston

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 35362

	Registrar Certificate of Death Reg No.
Physician/ Medical Examiner	November 2, 2000
Al rich	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Sinai Hospital 4c. County of Death Ac. County of Death
Funeral Director	5 Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8 Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Months Days Hours Min. 09-13-1932 maryland
Maryland 28a-f show any d.at once. ector	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No
ith the Maryland 23a or 28a-f sho notified at once. al Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216
fter death with t I", or items 23a ter must be not y Funeral I	11. Marital Status 1 Never Married 2 Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify Specify Specify
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene nr: If item 27 is marked other than "natural", or items 23a or 28a-f she rother tranmatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) NA Walk Market 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Samb Club
D 21215-0036 should be filed within 7 and Mental Hygiene 7 is marked other than natic event, the Medica To Be Comple	17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) 19 Informant's Name elationship (Type, Print) 19 Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
e, MD 2 1 and 2 shoul Health and N Titem 27 is n Traumatic	Lila Nich was - Sister 2315 Alskad Ln. Bavie, md. 20716 20a Method of Disposition 20b Place of Disposition (Name of cemetery, Date 20c Location - City or Town, State
.= = = 0	1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify Trinty Cemetery (1/14/06 Dund ack, mg.
	21. Sign x of Fune 1. Strice 1 of see 22. Name and Ad ress of Facility 270 Fred HITOM PASS Gary P. March Fune not bound to med, 2, 122 9 23a Party Integrate disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval
Physician /Medical Examiner	failure. List only one cause on each line. Immutate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of):
Jer Jer	Sequentially list conditions, if any, leading to immediate b
red I Insit Examiner	Course Enter to identying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):
58760, rrificate be executed ing physician and e as the burial - transit an/Medical Ex.	XUNPENDED #23a,27,perME,g861,11/14/06 TT
Division of Vital Records, P.O. Box 68760, for the Hospital or Attending Physiciau: The law requires that the death certificate be executed within 24 hours after death control of the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi edical Certification: To Be Completed by Physician/Medical Es	FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1
P.O. E ss that the d gned by the c detached I by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 V Unknown
Division of Vital Records, P.O ra or Attending Physiciau: The law requires that the raple death as therefore the After this certificate has been signed by led in by the funeral director, page 2 should be deate erification: To Be Completed by F	24a Was an autopsy performed? 1 Yes 2 ✓ No 1 Yes 2 No
Vital Rec ysiciau: The his certificate director, page	25. Was case referred to medical examiner? Hospital: 1 Inspital: 26. Place of Death (Check only one) Other, August Marco Harry 5 Decision 5 D
ion of Vi tending Physi eath or: After this the funeral dir	1 Ves 2 No learning Inpatient 2 ER/Outpatient 3 DOA Stress Nursing Home 5 Residence 6 Other: 27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation 28b Time of Injury (Month, Day, Year) 28b Time of Injury 28c Injury at Work? 28d Describe how injury occurred 1 Yes 2 No
Division ospital or Attending nours after death neral Director: After filled in by the function of the functio	3 Suicide 6 Could not be determined 28e Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Division To the Hospital or Attention 24 hours after death To the Funeral Director: completely filled in by the Medical Certificati	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 3, 2006
	30. Name and address of person who completed dause of death (Item 23a) Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
State Registrar	
DHMH 17 Rev 1/2001	ORIGINAL

		Plea	se Type or State o	Print in of Marylai						-		-	le.	
	For State Registrar		0.0.0	- Waryia	•		ate of				Reg. No	~ ~	0.5	3536
n	1. Decedent's Name Evelyn		•							2. Date of Do Month Nov	eath Da 8		/ear 5.	Time of Death O4 P M
d r	4a. Facility Name (II			mber)		4b. Cit	y, Town, o	r Location	of Death	NOV		. County of		04 P ^M
			Nursing H			_	kersv					reder	ick	
	5. Social Security N 220-14- Usual Residence of	9183	6. Sex 1 ☐ M 2 ☐ X F	7. Age (In yrs 80	. last birthday) Yrs.	Month:	ler 1 Year s Days	If Under Hours	Min.	8. Date of Bi (Month, D Aug 24	ay, Year)	9. Birthplace Country) arylan	(State or Foreig
	10a. State	10b. County		10c. C	ity, Town or Lo	ocation							10d. Ir	side City Limits
010	MD	Fred	derick	Fr	ederic	k							1	∏Yes 2 X ∏No
Ē	10e. Street and Nur						Zip Code						at Country?	
ā		ringric	lge Parkwa		10 10		1701			- " ' '		ted S		4:
Ĕ	11. Marital Status 1 □ Never Marri	ed 2□ Marri	Armed Fo	edent Ever in to proes? 27 4 No	J.S. 13.	If Yes, sp	pecify Cub	ispanic Or an, Mexica	rigin? (Sp in, Puerto	ecify Yes or No Rican, etc.)	0-		American In White, etc.	nan,
à	3 ⅓ Widowed		If Yes, Gi Year or D	ve		1 ☐ Yes	2 🔀 No	Specify	•			Specify:	White	
Be Completed by Funeral Director	(Spec	15. Decedent	's Education at grade completed)		16a. Dece	dent's Us	sual Occup work done use retired	ation	st of work	ina	16b. k	and of Busi	ness/Industry	
d	Elementary/Seco	ndary (0-12)	College (1-4or 5+)							E.	امعما	Carran	
2	17. Father's Name (First, Middle,	Last)		Natio	nar i	secur			e (First, Middle			_Gover	nment
	John Far							Mary				,		
	19a. Informant's Na	ame/Relationsh	nip (Type. Print)		19b. Maili	ng Addre	ss (Street	and Numb	er or Rui	al Route Numb	ber, City	or Town, St	ate, Zip Code	9)
	Rebecca	Elliot	t		306	Arro	w Woo	d Cir	cle	Mt. Ai	ry,	MD 21	771	
	20a. Method of Disp		3 ☐Removal from	20b. State	Place of Dispo cemetery, cre	osition (N matory o	lame of r other plac	ce)		Date	20c. L	ocation - C	ity or Town, S	itate
	4 □ Donation			s.								ield,		
21. Signature of Funeral Service Licensee 822. Name and Address of Facility Burrier-Queen Funeral Home and Cremate														
shock, or heart failure. List only one cause on each line.												784 roximate		
													Inte	val Between et and Death
	disease or condition resulting in death) Due to (or is a consequence of):													5 Da
		Total Control		V	440									/
ner	Sequentially list configure if any, leading to improve cause. Enter Under Cause (Disease or	nditions, imediate riving	Due to	(or as a conse	quence of):									
Examiner	Cause (Disease or that initiated events resulting in death) L	injury	с	/	0									
- 1	resulting in death, i	udi	Due to	(or as a conse	quence of):									
D			d							-				
Completed by Physician/Medica	IF FEMALE: 23b. Was decedent	t prognant		tcome pf pregr								23d. Date	of delivery	
Cla	in the past 12	menths?	4□Pregi	birth 2□Fe nant at time of			pregnancy (s <i>pecify)</i> _	/				Monti	,	Year
nys	9 □ Unknown		9□Unkn	own	*****								_	
Dy L	Part II. Other signif	icant condition	ons contributing to d	eath but not re	sulting in the u	ınderlying	g cause giv	en in Part	l.	23e. Did				ise of death?
red		PD								17	Yes 2	!□ No 3	☐ Probably	4 □Unknow
uble										24a. Was	psy	prie	or to complet	ndings available on of cause of
0										perf 1⊟ Yes	ormed?		ath? ∃Yes 2□	No
De	25. Was case refer examiner?	,	Hospital:		7-5-0		Oth			h (Check only				
0	1 Yes 2		28a. Date		28b. Time o		28c. Inju	34 N	ursing Ho	ome 5 Res				
100	1 ☑ Natural 2 ☐ Accident	5 Pending	9	nth, Day Year)	Injury	М		ƙ? Yes 2⊡] No			,		
erunce	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could r determ	and Zoe. Flace	e of injury - At I ing, etc. (Spec	nome, farm, sti	reet, fact	ory, office			28f. Location (City or To	Street a	nd Number e)	or Rural Rou	te Number,
Medical Certification:	29a. Certifier (Check only one)	Certifyin 2 Medical	g Physician: To the Examiner: On the b and man	e best of my kr pasis of examin ner stated.	nation and/or ir	nvestigati	ion, in my	pinion, de	ath occur	red at the time	, date ar	d place, an	d due to the	cause(s)
	29b. Signature and	title of certifier	7			2	29c. Licens	e number			29d. Da	ate signed (Month, Day,	Year)
Me	L Va.	1					D	7/1	. 2			-	- /	
Me	- 1/W						-	3/6	7 5		/ /	- 0 -	01	
Me	30. Name and addr	ess of person	who completed cau	se of death (Ite	em 23a) (Type,	Print)		3/60	13	honson		- 9 -	e Neni	1 mo

10

Registrar

* -		~ .
State of Maryland /	Department of Health and Mental Hygiene 2 0	J (

			For State Registrar	State of Ma		artment of I <i>rtificate of</i>		nd Mental Hyg	giene U	Ub	35364
	Physici /Medi		Decedent's Name (First, Middle, Las	-	I. Alban			2. Date of Dea Month Novembe:	Day	06	3. Time of Death 6:15 P M
Special Con-	Examir		4a. Facility Name (If not institution, give Keswick MultiCare			4b. City, Town, Baltin	nore		4c. County	of Death	
	Funeral Director		5. Social Security Number 6. Security Number 11 6. Security Number 219–18–1634	9x 7. Age	e (In yrs. last birthday, 81 Yrs.	If Under 1 Year Months Days		Min. June 26	, 1925	9. Birthp Coun Mary	lace (State or Foreign ity) Land
	a-f show	ctor	10a. State 10b. County Maryland N/A		10c. City, Town or L	ocation Baltimore)			1	0d. Inside City Limits 1XXYes 2 □ No
	th with the 23a or 28	Funeral Directo	10e. Street and Number 918 W. 38th Str	eet		10f. Zip Code	2121		10g. Citizen of		ury? USA
980	s 1 and 2 should be liled within 72 hours elter death with the Maryland Heelth and Meniel Hygiene. Item 27 is marked other than "naturel", or Itams 23a or 28a-f show other treumatic avent, the Madical Examiner must be notified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 5 orced	12. Was Decedent E Armed Forces? 1 ☐ Yes ※XX N If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 2 No		n? (Specify Yes or No- Puerto Rican, etc.)	14. Rad Bla Specif	ce - Americ ck, White, y: W	
21215-0036	within 72 ho iene. r than "natur ihe Wadical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 9th		(Give	dent's Usual Dccu kind of work done DO NOT use retire Lad Maker	during most o	of working	16b. Kind of B		try Club
Maryland 2	2 should be filed within and Mentel Hygiene. Is marked other than eumatic avent, the M	0	17. Father's Name (First, Middle, Last) Elmer Freeman					s Name (First, Middle, Davis	Maiden Suman	ne)	
	1 end 2 sho Heelth and em 27 is my other treums		19a. Informant's Name/Relationship (7 Tomalyn Fox 20a. Method of Disposition	ype, Print) Daughter		v. 38th S		or Rural Route Numbe Baltimore	•	and 2	1211
Baltimore,	t. Page riment o rient: If		1 Burial 2 Cremation 3 4 Donation 5 Other (Specify)	Metro Cre	matory or other pla	1	1/10/06			, Maryland
Ba	Physician		23a. Fast! Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	asperte		Burgee-He 3631 Fall	enss-Se s Road ing, such as ca	itz Funera Baltimore ardiac or respiratory ar		Inc. land	21211 Approximate Interval Between Onset and Death
58760,	/Medical Examiner hysicien and he burial-transit	edical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	a consequence of): a consequence of): a consequence of):	C // /					m mJh
O. Box 6	The law requires that the death certificate hes been signed by the attending plyage 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetal death 3	□Ectopic pregnand □ Other (specify) _	су			te of delive	ny Day Year
<u>α</u>	quires that I n signed by uld be deta	þ	Part II. Other significant conditions or	ontributing to death bu	ut not resulting in the u	inderlying cause g	iven in Part I.	_	_		e cause of death? ably 4 □Unknown
I Records,	The law require	Completed							rmed2	Were autor prior to cor death?	psy findings available inpletion of cause of
Vital	Physician: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	II II-I				f Death (Check only or	пе)		
of	W 17	2	1 Yes 2 No		nt 2 ER/Outpatie	III 3 DOA		ing Home 5 Resid			1)
Division o	ling After une	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		y Year) 28b. Time of Injury	M 1	Yes 2 □ No	28d. Describe h			(Control No.
Div	2 th = -		4 Homicide determined 29a. Certifier 1 Certifying Ph	building, etc	c. (Specify)			City or Tow	m, State)		
	To the Hospital of within 24 hours of To the Funeral D completely filled in	Medical	(Check only 2 Medical Examone) 29b. Signature and title of certifier	niner: On the basis of and manner sta	examination and/or in	vestigation, in my	opinion, death	occurred at the time,	date and place, 29d. Date signe	and due to	the cause(s)
	T V V		· M And	They 10 completed cause of de	lly or			St. Bal			*
	14		WA A CRITE	C BM	(/ 10 70)	1 N. a	harles	St. Bal	A ind	20	2014

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

NOV 0 9 2006

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month.

Day,

Year)

0

32 Registrar's Signature

			For State Registrar		State of	Marylar		artmen			and M	lental Hy		2006	35366
1	Dhusisi		1. Decedent's Name (First,		t)							2. Date of De	ath		3. Time of Death
	Physici /Medic		Audre		cooks							Novemb	er 8	å, 2006	
1000	Examin	er	4a. Facility Name (If not inst					1		Location of			4	c. County of D	
		\$.	9906 Cervida 5. Social Security Number	ae Lar			last birthday)	-	Inda.	1stov		8. Date of Bir	rth		imore Birthplace (State or Foreign
<i>M</i> .	Funeral Director		456-64-5876		м Ж ДЕ		53 Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da April 1	ау, Үөаг 1	943 Ma	country) aryland
	D.		Usual Residence of Decede			140.00							- ,	7 10 T 1	
	anyla shov	5	10a. State 10b. C	. ,		100. Cit	ty, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 ∑ No
	28a-f	ecto	Maryland Ba	ltimo:	re		Randa.	LLS tov					100.0	itizen of What	
	3a or		9906 Cervid	ae Iai	ne Apt.#	 #3		101. 240	21:	133			rog. C	USA	Country:
	death	Funeral Director	11. Marital Slatus		12. Was Deced	lent Ever in U	J.S. 13.	Was Deced			gin? (Spe	ecify Yes or No Rican, etc.)	D-	14. Race - A	merican Indian,
9	or Ite	교	1 Never Married 2X		1 Tes 2		1	1 ☐ Yes		Specify:	i, Pueno	Hican, etc.)		Black, W Specify: 7	
Ö	72 hours after death with the Maryland insturel; or Items 23e or 28e-f show disal Examinat must be notified at	d by	3 Widowed 4 Div	orced cedent's Ed	Year or Dat	tes:								V	√hite
7.	in 72	Completed	(Specify only	highest grad	de completed)		(Give	dent's Usua kind of wo DO NOT us	rk done d	turina most	t of work	ing	166.1	Kind of Busine	ss/Industry
212	e filed within al Hygiene. I other then "	mo;	Elementary/Secondary (0	-12)	College (1-	4or 5+)	Cas	shier						Food Ir	ndustry
pu	al Hy d oth	Be	17. Father's Name (First, M	iddle, Last)								e (First, Middle		n Sumame)	
<u>y</u>	2 should be and Mental Is marked o	P	Albert W.									Heicem			
Maryland 21215-0036	nd 2 sh alth and 27 is m r traum		19a. Informant's Name/Rei			1						al Route Numb			
ďΣ	4 5 E E		Emmett W. 20a. Method of Disposition	DEOOKS	s, Husba		Place of Disponentery, cre	osition (Nar	ne of	Lane		∙#3 Kan Date			MD 21133 or Town, State
ē	Pages ent of nt: If II		1 ☐ Burial 2 ☐ Crema 4 ☐ Donation 5 ☐ Ott			iale	cemetery, cre.			1	11/0	9/06			
Baltimore,	permit. Pages 'Department of H Important: If Ite any Injury or ot once.		21. Signature of Funeral Se	rvice Dicen:	SAA	1100	2	2. Name an	d Addres	s of Facilit	y), OO	Da.	TOTHIOLE	e, Maryland
m	Depa Impo any I		Thomas G	regor	8			199 Fr	eder:	ick F	ety (Road	Ji Mary Baltim	land	d, Inc. Marvl	and 21228
			23a. Part1. Enter the disea shock, or heart failure	se, or comp . List only o	olications that ca one cause on ea	used the deat ch line.	th. Do not en	ter the mod	e of dyin	g, such as	cardiac o	or respiratory a	rrest,	,, -	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	_	a. Ca	rchor	e) piro	dory	C	irros	7				Onset and Death
	/Medical Examiner		, seeming in south,		Due to (o	r as a consec	quende of):	J							
	*	er	Sequentially list conditions, if any, leading to immediate		b. Due to (a	r as a consuc	querice of):								
هر	cutéd nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	1	С.										
Ő,	be executician and burial-tran		resulting in death) Last		Due to (o	r as a consec	quence of):								
8760,	icate be executéd physician and s the burial-transit	dlcal		•	d									_	
9 X	death certificate e attending phys id for use as the	/Med	IF FEMALE:		23c. If yes, outco	ome of prean	ancv							22d Date of	deline
Вох	death a atter	Physician/M	23b. Was decedent pregna in the past 12 months' 1 ☐ Yes 2 MNo	3 11	1☐Live bir	th 2 ☐ Feta nt at time of c	al death 3[Ectopic pr Other (sp						23d. Date of Month	Day Year
P.O.	that the death ned by the atter detached for u	hys	9 Unknown		9□ Unknov	₩n									
	9 . jo	by P	Part II. Other significant co				sulting in the u	inderlying c	ause give	en in Part I.		23e. Did 1	tobacco		to the cause of death?
ord	v requir been s should				Mellit	us						10	Yes 2	2 □ No 3) 5 —	Probably 4 Unknown
3ec	0 = 0	Completed		OP)								24a. Was auto	DSV	prior	autopsy findings available to completion of cause of
a	The Sag										-	1 ☐ Yes	-	death	'es 2□ No
₹	ysician: is certific director.	o Be	25. Was case referred to mexaminer? 1 Yes 2 No	-	Hospital:	patient 2	ER/Outpatie	nt 3 DC	Othe			me 5 Resi	100	2 Flow /2	
1 0	Attending Physician: r death. ector: After this certificaby the funeral director.	 	27. Manner of Death		28a. Date of		28b. Time o		8c. Injury Work	4 🗆 140		28d. Describe			pecify)
ior	endin sath. or: Aft he fur	atlo	2 Accident	ending vestigation		, Day 16ai)	Injury	М		Yes 2 1	No				
Division of Vital Records,	or Att	Certification:		ould not be etermined	28e. Pface of building	of Injury - At h g, etc. <i>(Specil</i>	ome, farm, st	reet, factory	, office			28f. Location (City or To	Street a	and Number or te)	Rural Route Number,
	Hospital	Ce	29a. Certifier 1	dibitan Dh	inicion. To the h	and of while from		. Indicate of	22/22/2-2/5	I Desired	**************************************	SILVERS CASSASS	THE WAY IN		- Anna Carlo
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral.	edical	(Check only 2 Me	dical Exam	ysician: To the b liner: On the bas and manne	sis of examina	ation and/or in	vestigation	, in my of	oinion, deal	th occurr	ed at the time,	date ar	s) and murner nd place, and c	due to the cause(s)
	To the within 2 To the Complet	Me	29b. Signature and title of c	ertifier	- 11			290	. License	number			29d. D.	ate signed (Mo	onth, Day, Year)
					2 W	- 1	70	2)00	6368	51		11	18/06	
	le		30. Name and address of p		completed cause	of death (Iter	m 23a) (Type,	Print)		. *,	m)) 4101	1,0	1	
	-		AJIT KURUP 31. Date filed (Month, Day,	1/5				u 13	urn	1 4	rug) 4100			
	Sta Registi			/ n 9		gistrar's Signa	a.uie ()	Social							

ORIGINAL

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryla		artment of H rtificate of L			giene Reg. No. 0	6 35367
	Physici		1. Decedent's Name (First, Middle, Lass DONALD	·	YAN			2. Date of De Month NOVCM	Day	Year 3. Time of Death
	/Medio Examin		4a. Facility Name (If not institution, give			4b. City, Town, or BALTIM			4c. County o	
	Funeral Director		5. Social Security Number 6. Se		rs. last birthday) 77 Yrs.		If Under 24 h	Hrs. 8. Date of Bir lin. (Month, Da April 1	th ly, Year)	9. Birthplace (State or Foreign Country) Maryland
	Aaryland 6 ehow	or	Usual Residence of Decedent 10a. State 10b. County		City, Town or Lo		_	•		10d. Inside City Limits 1 ☐ Yes 2 💆 No
	a with the h	i Director	Maryland Baltimo: 10e. Street and Number 2929 Louisiana Av		Balt	imore 10f. Zip Code 21	227		10g. Citizen of WI	
36	72 hours after deeth with the Maryland natural', or items 23a or 28a-f ehow assal Examiner must be natified at	by Funerai	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give				(Specify Yes or No Jerto Rican, etc.)	14. Race Black	- American Indian, , White, etc. White
21215-0036	1 within 72 hour plane. r than "natural"	Completed b	15. Decedent's Ed (Specify only highest gran		16a. Deced	dent's Usual Occupa kind of work done o DO NOT use retired	ation furing most of	working	16b. Kind of Bus	
	be filed wit tal Hygiene d other the	Ве Соп	17. Father's Name (First, Middle, Last)	0011090 (1140134)	Truc	k Driver	18. Mother's i	Name (First, Middle,		g Company
Maryland	s 1 and 2 should be filed f Health and Mental Hyg item 27 is marked othe other traumatic event,	2	John Bryan 19a. Informant's Name/Relationship (7)	ivna Print)	10h Mailie	Address (Street		rgaret Jo		No. 4 Tip Co. do.)
	and 2 s alth an 127 is or traus		Marnie Ford, Day	•	1			Halethor		
Baltimore,			20a. Method of Disposition 1 □ Burial 2 ▼□ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	•	sition (Name of natory or other place matory In	· 1	Date /09/06		e, Maryland
Balt	permit. Page Department of Important: If any injury or		21. Signature of Funeral Service Licen- Thomas Gregori	500	22 2	Name and Address remation 99 Freder	Society Society ick Ro			vland 21228
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. GANGRE	ath. Do not ent	er the mode of dying	g, such as card	diac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	/Medical Examiner	70	Sequentially list conditions, ray, bading to installate cause. Enter Underlying	b. Due to for as a cons	FIBRI					4-0
8760, 8	cate be executed physicien and the burial-transit	dicai Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. ATHEROSO Due to (or as a cons	CLENOT	1C CAA	2010 V	AS CULAR	- DISONE	the hoose
.O. Box 68	at the death certifica by the attending ph itached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time o 9 □ Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date Mont	of delivery h Day Year
<u>α</u>	gned be de	þ	Part II. Other significant conditions on PENM (NEW FRIT		esulting in the u	nderlying cause give	on in Part I.			oute to the cause of death?
of Vital Records,	The ete h page	Completed	HTN					24a. Was autor perto	rmed?// de	ere autopsy findings available for to completion of cause of ath? Yes 2 No
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		Othe		Death (Check only o		
ion of	ding h. After fune	ertification: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	4 Nursing	g Home 5 Resident Res	dence 6 Other	
Division	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	O	3 Suicide 6 Could not be determined	building, etc. (Spe	cify)			City or Tox	vn, State)	r or Rural Route Number,
	To the Hosp within 24 hou To the Funel completely fil	Medicai	one) Z Medical Exam	rsician: To the best of my k iner: On the basis of exami and manner stated.	nation and/or inv	restigation, in my op	inion, death o	ccurred at the time,	date and place, ar	nd due to the cause(s)
)	T Y C		29b. Signature and title of certified	Melone 1	40	29c. License	number		29d. Date signed	(Month, Day, Year)
	4		30. Name and address of person who de	completed cause of death (It	өт 23а) (Туре,	Print) HAR	Bor	Hospie	7L	107/2006
3 G	Sta Registr	_	31. Date filed (Month, Day, Year) NOV 0 9 2	32. Registrar's Sig	nature	facts				

		-	Plea							Ensure A			•		
		1 = For State Registrar				,	•	rtificat				Reg. N		0000	
	4	1. Decedent's Name	e (First, Middl	e, Last)							2. Date of D	eath	2000	3. Time of Death	
hysicia /Medic		Frieda		J	Γ.		Ba	iley			Novemb	er 3		5:35 A ^M	
Examin		4a. Facility Name (II		_	and number)			4b. City,	Town, o	r Location of Dea		4c. County of Death			
		Gilchrist		ce					[ows				Baltimor	re	
ineral		5. Social Security N		6. Sex 1 ☐ M			as <i>t birthd</i> ay) Yrs.	If Under Months	1 Year Days	If Under 24 Hrs Hours Min		rth ay , Yea	9. Birt	hplace (State or Foreign untry)	
rector		227–22–19 Usual Residence of			-X-	81	115.				August	12,	1923 Vi	rginia	
M T		10a. State	10b. County			10c. City	, Town or Lo	cation						10d. Inside City Limits	
-f sh	ģ	Maryland	Balti	more			Dund	alk						1 □ Yes 2 🛣 No	
r 28a	irec	10e. Street and Nur	mber					10f. Zip	Code			10g. C	itizen of What Co	untry?	
23a o ist be	Funeral Director	1830 Mars	hall R	oad						21222			USA		
er mu	ner	11. Marital Status		12. V	Vas Decedent rmed Forces?	Ever in U.	S. 13.	Was Deced	ent of H	lispanic Origin? (an, Mexican, Pue	Specify Yes or N	0-	14. Race - Ame Black, White		
or it	3	1 Never Marri	**	ried 1	☐ Yes 2☐X Yes, Give			1 ☐ Yes		Specify:	,		Specify: Wh		
ural"	d by	3 Widowed			ear or Dates:							1.01			
"nat edica	Completed		ify only highe	t's Education st grade con	n npleted)		(Give	dent's Usua kind of wor DO NOT us	rk done	during most of we	orking	160.	Kind of Business/	industry	
than he M	ЩС	Elementary/Seco	ndary (0-12)	C	College (1-4or	5+)		sewife		-/		Ow	n Home		
ent, t	Be	17. Father's Name	(First, Middle,	Last)		l	nou	SCWII		18. Mother's Na	me (First, Middle				
ic ev	To B	George W.	Dowel	1						Gracie	e Philli	ps			
umat	-	19a, Informant's Na	ame/Relations	ship (Type. F	Print)								or Town, State, 2		
er tra		Jackie Sh	erman	Daug	ghter		7617	Spru	ce R	toad, Dur	ndalk,Ma	ryla	ind 21222	2	
r oth		20a. Method of Disp		2 DRama	ual from State	C	lace of Dispe	matory or o	ther pla		ember		ocation - City or		
ant: I		4 □ Donation			vai iroini State	Mea	adowri	dge C	emet	ery 6,	2006	Elk	ridge, N	Maryland	
21. Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P. A Connelly Funeral Home Of Dundalk, Mary													lalk, P.A.	•	
115		23a. Part1. Enter to shock, or hea		complication to complication t	ns that cause use on each li	d the death ine.	n. Dørngt en	ter the mod	e of dyir	ng, such as cardia	ac or respiratory	arrest,		Approximate Interval Between Onset and Death	
sician		Immediate Cause (disease or condition resulting in death)	Final n	a		00	/ 1 *	· Au		CANC	er			years	
edical miner		}			Due to (or as	a consequ	uence of):							0	
	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):													
ansit	Examiner	Cause (Disease of Injury that initiated events C.													
an an rial-tr	Exa	that initiated events c													
attending physician and for use as the burial-transit	ical	_													
ng ph	Physician/Medica	IF FEMALE:													
tendi or use	an/I	23b. Was deceden in the past 12			yes, outcome □Live birth			□Ectopic pr	egnanc	/			23d. Date of del Month	ivery Day Year	
the at	sici	1 ☐ Yes 2 ☐ 9 ☐ Unknown	No		I□Pregnant a I□Unknown	t time of de	eath 5	Other (sp	ecify) _				WOTH	Day Teal	
d by detacl		Part II. Other signit		ons contribu	iting to death h	out not resu	ulting in the	nderlying c	ause niv	en in Part I	23e. Did	tohacco	use contribute to	the cause of death?	
signe d be	l by				9		g	, , ,	g				_	obably 4 □Unknowr	
been	etec										24a. Wa:	200	24h Wara a	stepper findings overlight	
ge 2	Completed										auto	psy ormed?	prior to death?	topsy findings available completion of cause of	
ificate or, pa	ပိ	25. Was case refer	red to medica	al l						26 Place of De	1□ Yes eath (Check only	2 1	o 1 ☐ Yes	2 □ No	
s cert	To Be	examiner?	/	Hospi	tal: 1 ☐ Inpati	ent 2∏	ER/Outpatie	nt 3∏ DC	Oth	er:			6 Other (Spe	city Hasni	
er this		27. Manner of Deat	h		Ba. Date of Inju	ury	28b. Time of		8c. Injui Wor		28d. Describe			city) (10 apr	
r: Aft le fun	atio	1 ☑ Natural 2 ☐ Accident	5 ☐ Pendii invest		(Month, Da	ay rear)	Injury	М		Yes 2 ☐ No					
recto	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 □ Could deterr		Be. Place of in building, e	jury - At ho tc. <i>(Specif</i>)	me, farm, st	reet, factory	, office		28f. Location City or To			ıral Route Number,	
ra Del															
Section Part 1.															
mple	Medical	one) 29b. Signature and	title of certific		and manner st	tated.		290	Licens	e number	1	29d D	ate signed (Mont	h Day Voarl	
P 8	-	29b. Signature and	A	Then	. the	le	· m) /)	2010		1/	ate signed (Mort	. Q Dola c	
		20 Nome 27 de d	1/ V C	y bo sa	atod course of	dooth (22a\ /T	Print\	10			1 4 6	venu	0,2006	
8		30. Name and addi	2 S (who comple	3m	1 /-	7 <i>0</i> /	N. C	lin	les J	Ba	640	. md	21206	
Sta	ite	31. Date filed (Men			32. Regist		ture A	and the		- 0,	12-0-				
Registr		N	OV 0 S	2006	Se Se Se Se Se Se Se Se Se Se Se Se Se S	bed sh	d'a state of	No. of the last of							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #2 Per Physics Maryland Department of Health and Mental Hygiene Reg. No. 2 06 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Roma Bose November 2, 1006 7:25 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year)
Nov. 20, 1936 Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🗓 F Months Hours Yrs. 69 India Director N/A Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and of Health and Mental Hygiene. and it flem 27 is marked other then "nature!", or iteme 23a or 28a-f ehow ury or other freumatic event, the Medical Examinal must be mailted and ury or other freumatic event, the Medical Examinal must be mailted as 10a. State 10c. City, Town or Location 10d. Inside City Limits N/A 1 Yes 2 No Director N/A Allahabad 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 211002 187-A Colonel Gang India Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ♥ No Specify: Specify: Asian Indian þ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Public Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nakuleshwar Mitra Shailbala 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar Importent: If Item 27 is eny injury or other treu 2002. Rita Mitra / Sister 10810 Torrance Dr., Kensington, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 11/4/2006 Beltsville, MD 21. Signature of Funeral Service Diceasee 22. Name and Address of Facility

Rapp Fueral & Cremation Sers., Silver Spring, MD
20910 22. Name and Address of Facility M00382 Rapp Fueral & Cremation Sers .

23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Chronic Myelogenous Leukemia Unknown /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner To the Hospital or Attanding Physician: The law requires that the death certificate be executed ettending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. s been signer should be d Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4XX inknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s hes autopsy performed? certificate 1 Yes 2X No 1 ☐ Yes **⊉**Q₩0 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To ¹1 ☐ Yes 2√XNo 1 Tinpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1XXVatural 5 Pending 1 ☐ Yes 2 ☐ No nerel Director: A y filled in by the ft investigation 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide within 24 hours a To the Funeral [Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check onl one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D58681 November 3, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Dr., Rockville, MD Judy Alexander M.D. 31. Date-fied (Month, Day, Year) NOV 0 8 2006 32. Resistrar's Signature State

Registrar

7		Please 1 - For State Registrar	Type or P State of		d / Depa	artmen	t of H		and M	-		า ก ี	ble.	3537	
Physic /Medi		Decedent's Name (First, Middle, La Robert E. Beal	,			imoun	011	Doain		2. Date of D Month		y _	Year	3. Time of Death	
Exami		4a. Facility Name (If not institution, gire	re street and numb			_	_	Location o		MARCHI		. County		'a	
Funeral Director			Sex 7.	. Age (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, L	irth Day, Year)		9. Birthp	9. Birthplace (State or Foreign Country) Maryland	
Maryland -f show	tor	10a. State 10b. County MD n/a		10c. Cit	y, Town or Lo	cation	••						1	0d. Inside City Limi	
with the 3a or 28a at be not	I Direc	10e. Street and Number 3018 Janice Ave.	•		Dai	10f. Zip	Code	1230			10g. Ci	tizen of V	Vhat Cour	ntry?	
within 72 hours efter death with the Maryland ene. Hen "naturel", or items 23s or 28s-f show he Madical Exemirer must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deced Armed Forc 1 XYes 2 If Yes, Give Year or Date	es?	1	Was Deced f Yes, spec	ent of H		gin? (Spo , Puerto	ecify Yes or N Rican, etc.)	10-		e - Americ k, White,	an Indian, etc.	
within 72 ho iene. then "natur ne Medical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)		lor 5+)	life. L	kind of wor DO NOT us	k done d e retired	during most	t of worki	ing			siness/Ind	dustry	
uld be filed Aental Hygi rked other tic event, I	To Be Co	17. Father's Name (First, Middle, Last Eldridge C. Bea)		UAI	pente	L			P. Ha	e, Maider			timore	
permit. Peges 1 and 2 should be filed within 72 hours efter death with the Marylan Depertment of Health end Mental Hygiene. Important: if itsm 27 is marked other than "natural; or itsms 23a or 28a-1 show any injury or other treumatic event, the Modical Examinat must be notified at once.		19a. Informant's Name/Relationship (Kathryn I. Beall 20a. Method of Disposition 1	/ Wife_	ate C	3018 lace of Disposemetery, cren	Janic sition (Nam	e Av	re. I	Balt:	inore	Mary	land		30	
permit. Pege Depertment of Importent: if eny injury or pncs.	4 Donation 5 Other (Specify) Clen Haven Mem. Park 11/7/06 Glen Burnie 21. Signature of Funeral Service Licensee 3620 Wilkens AVe. Baltimore, Marylan											al H	оте		
Physician /Medical Examiner		23a. Pan1. Enter he disease, or con shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	a. Ac	ai line.	7704					or respiratory	1			Approximate Interval Between Onset and Death	
executed on and rial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or	as a consequ	uence of):	142	AR	x 1	D (>	EASE				LAVASY	
at the death certificate be by the attending physici tached for use as the bu	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		h 2 ☐ Fetal it at time of de	death 3	Ectopic pre Other (spe						23d. Date Mon	of delive	ry Day Year	
w requires that been signed b should be deta	þ	Part II. Other significant conditions of	ontributing to deat	th but not resu	ulting in the un	derlying ca	use give	n in Part I.			tobacco u	_	bute to th	e cause of death?	
	Completed	25. Was case referred to medical							_	1 Yes	psy ormed? 2₩ No	Di de	rior to com	usy findings availab apletion of cause of	
ysicien: nis cartific i director,	To Be	examiner? 1 Yes 2 No	Hospital: 1 _ fnp	atient 2 💢	R/Outpatient	3 DO	Othe			Check only		5 □Othe	r (Specify)	
Attending Physicien: r deeth. sctor: After this cartificator: After the funeral director.	Certification:	27. Manner of Death 1	1	Injury Day Year)	28b. Time of Injury	M 28	C. Injury Work	at ? ′es 2 ∐ N	2	28d. Describe	how injur	y occurre	ed .		
To the Hospital or Attani within 24 hours after deal. To the Funeral Director: completely filled in by the		4 Homicide determined	28e. Place of building,	, etc. (Specify) 					City or To	wn, State)		Route Number,	
n 24 ho	Medical	(Check only 2 Medical Exam	ysician: To the be niner: On the basis and manner	s of examinat	viedge, death ion and/or invi	occurred a estigation,	t the time in my op	e, date and inion, death	l place, a h occurre	and due to the	date and	place, a	ner as sta nd due to	ited. the cause(s)	
To the within 2 To the complet	ž	29b. Signature and title of certain	SD			1		number	\$				(Month, E		
le		30. Name and address of per on MARCTH ACTH	cause o	of death (Item	23a) (Type, P	Print)	(Ve	~~~	Ave	#30	· ·	BALT	2040	2006 2006	
Sta Registr		31. Date filed (Month, Day, Year)		istrar's Signat		Karek	M. B.								

DHMH 17 Rev 1/2001

		Ple	ase Type o								,	gible.		
		For State	State	of Ma	aryland		artment of rtificate of		d Men	,			0.50	
	0.	Registrar Decedent's Name (First, Mid	dle, Last)			Cer	illicate of	Dealli	2. [Date of De	Reg. No	lUb	3. Time of D	Death
Physic /Med		Ethe	el P. Ba	ıldw ⁻	in				No	V. 7	, 2 <mark>0</mark> 06	Year	11:35	Ам
Exam		4a. Facility Name (If not institut	ion, give street and n Care Ruxt					or Location of Di	eath			nty of Dear Baltin		
Funera		5. Social Security Number	6. Sex		e (In yrs. las	st birthday)	If Under 1 Year Months Days	r If Under 24 I	Hrs. 8. D	Date of Bir Month, Da	th	9. Bir	thplace (State or	Foreign
Directo		180-10-5109 Usual Residence of Decedent	1 □ M 2 □ X F		87	Yrs.	Months Days	Hours N	In. Ju	ine 5	, 1919		ginia	
ryland how at		10a. State 10b. Coun	ty		10c. City,	Town or Lo	cation					<u> </u>	10d. Inside City	Limits
he Ma 28a-f s otifled	Director	Md .	Baltimore					nonium			40077	(11/1/2) 0	1 □Yes 2	2 X No
3a or	ğ	219 Burning	Tree Rd.				10f. Zip Code	21093			10g. Citizen	USA	ountry?	
r death	Funeral	11. Marital Status	12. Was De	Forces?	Ever in U.S.	13.	Was Decedent of If Yes, specify Cu		? (Specify uerto Ricar	Yes or No n, etc.))- 14. F		erican Indian, e. etc.	
J36 urs afte	by Fi	1 ☐ Never Married 2 ☐ Ma 3 ☐ XWidowed 4 ☐ Divorce	If Yes (s 2[X 1 Give Dates:	10		1⊡Yes 2⊠No	Specify:				cify:	White	
(1215-U036 within 72 hours after death with the Maryland ene. than "natural" or items 23a or 28a-f show by Medical Examiner must be notified at	eted	15. Deced	ent's Education hest grade completed	d)		16a. Deced	dent's Usual Occi kind of work done DO NOT use retire	upation o during most of	workina		16b. Kind of	Business		
Z Z Z J S-U string within 72 h giene. If than "natu the Medical	Completed	Elementary/Secondary (0-12 10) College	(1-4or 5	i+)		po <i>not use retir</i> phone Ope		J		Col	mmuni	cations	
W < 0	Be C	17. Father's Name (First, Middl				icicp	mone ope		Name (Fir	st, Middle	, Maiden Surr		Cations	
Maryland d 2 should be file th and Mental Hy 77 Is marked oth traumatic event	일		in M. Stro	uth		401 14 11		1			. Comp			
re, Maryle s 1 and 2 should f Health and Mer ttem 27 Is marke other traumatic		19a. Informant's Name/Relatio					ng Address <i>(Stree</i> Burning 7							
or Hez		20a. Method of Disposition 1 X Burial 2 □ Cremation	n 3 □ Bemoval fro	m State	20b. Pla		sition (Name of natory or other pl		Date		20c. Locatio			
Baltimore, permit. Pages 1 a Department of Her Important: If Item any injury or othe		4 □ Donation 5 □ Other 21. Signature of Experies Service	(Spacify)		Guins		ited Prest		1/13/	06	Chance	ford	Pennsyl	<u>vania</u>
Depa Impo		21. Signature in the river in t	e Licerisee			_ 22		York R					Home In	с.
Part .		23 Part . Enter the di pase, shick, or heart failur	or contilications that ist only one cause or	t caused each lir	the death.	Do not ent						04	Approximate Interval Between	een
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	-Jr	nPh	oma							Onset and De	eath
Examine			b	o (or as	a conseque	ence ot);								
a e o	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		o (or as	a conseque	ence of):							-	
e executivan and urrial-tran	Exan	that initiated events resulting in death) Last	c	o (or as	a conseque	ence of):		-	·					
ords, P.O. Box 68/60, Ce requires that the death certificate be executed een signed by the attending physician and hould be detached for use as the burial-transit	dical		d											
BOX 6 ath certific	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o								23d.	Date of de	livery	
b. b e death he atte	sicial	in the past 12 months? 1 □ Yes 2 🔀 No		gnant at	2 ☐ Fetal of time of dea		∃Ectopic pregnan ∃Other (s <i>pecify)</i>	су			1	Month	,	ear
that the		9 ☐ Unknown Part II. Other significant cond			ut not result	ing in the u	nderlying cause g	iven in Part I.	- 1	23e. Did t	obacco use c	ontribute to	the cause of de	ath?
ecords, P.O. law requires that the de as been signed by the a 2 should be detached	ed by								_		Yes 2 □ No		robably 4 ⊠ Ur	
S S S S S S S S S S S S S S S S S S S	Completed								_ [24a. Was auto	psy	b. Were at	utopsy findings av	vailable use of
ate da da da da da da da da da da da da da		25. Was case referred to media	02				_			1□ Yes	2 No	death? 1 ☐ Yes	2 kat No	
Or VITA Physician: this certifical director,	To Be	examiner? 1 ☐ Yes 2 ☑No	Hospital:	 Inpatie	nt 2 El	R/Outpatier	nt 3□ DOA O	26. Place of ther: 4 🖼 Nursin			o <i>ne)</i> dence 6 □0	Other (Spe	cify)	
L ge lei		27. Manner of Death 1 ☑ Natural 5 ☐ Pend	unig .	te of Inju onth, Day		28b. Time of Injury	W	ury at ork? ☐ Yes 2 ☐ No	28d.	Describe	how injury occ	curred		
UIVISION al or Attending after death. I Director: After d in by the fune	Certification:	3 Suicide 6 Coul	rmined 28e. Pla	ce of inju	ury - At hom c. <i>(Specify)</i>	ne, farm, str	eet, factory, office		28f. L	ocation (Street and Nu	mber or Ri	ural Route Numb	er,
oltal or urs afte aral Dir											wn, State)			4
To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical	29a. Certifier 1 → Certifier (Check only 2 → Medicone)	ying Physician: To t al Examiner: On the and ma	he best of basis of anner sta	examination	ledge, deati on and/or in	h occurred at the vestigation, in my	time, date and p opinion, death o	lace, and o	due to the t the time,	cause(s) and date and place	manner as ce, and due	s stated. e to the cause(s)	
)	Σ	29b. Signature and title of certi	Araa	le	· D.	0.	Į	0 5 4 4	24		29d. Date sig			
10		30. Name and address of person	on who completed ca	use of d	eath (Item 2	23a) (Type,								
	tate	31. Date filed (Month, Day, Yea	30 2006 32	Registra	ar's Signatu	ré	Print) Print) Print) Print)	707			1717/1			
Regis	trar	MOA ()	9 2000									***		

			1 - State of Marylai Registrar	nd / Depa <i>Ce</i> :	artment of He	ealth and I Death	Mental Hyg	iene2 0 0 6	35372
			Decedent's Name (First, Middle, Last)				2. Date of Deat	h	3. Time of Death
	Physicia /Medic		Irene Butter bau	igh			Month	Day Year	3:50p. M
	Examin		4a. Facility Name (If not institution, give street and number)	- 3	4b. City, Town, or L		1	4c. County of Death	
			Charlestown Care Center			sville		Baltin	
	Funeral Director		218-18-8023 ^{1□M 2} 85	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept. 4,	Year) 1921 Maryl	place (State or Foreign ntry) Land
	pug *		Usual Residence of Decedent 10a. State 10b. County 10c. C	City, Town or Lo	ocation				0d. Inside City Limits
	Aaryk reho	5							1 ☐ Yes 2 ☑ No
	the t	Director	Maryland Baltimore	Catons	10f. Zip Code		1	0g. Citizen of What Cour	ntry?
	death with the Maryland me 23a or 28a-f ehow r must be notified at		719 Maiden Choice Lane #BR316		21228			USA	y.
	death me 2	era	11. Marital Status 12. Was Decedent Ever in I	U.S. 13.	Was Decedent of His If Yes, specify Cuban	panic Origin? (S	pecify Yes or No-	14. Race - Americ	
٥	or ite	by Funeral	1 ☐ Never Married 2⊠ Married 1 ☐ Yes 2 ☑ No		If Yes, specify Cuban, 1 ☐ Yes 2 A No	, Mexican, Puert Specify:	o Rican, etc.)	Black, White,	_
3500-6121 <i>2</i>	urel',		3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		TE TOS ZEINO	эреспу:		Specify: WII	
7	natu	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupat kind of work done du	ion ring most of wor	king	16b. Kind of Business/In	dustry
7	withir	d L	Elementary/Secondary (0-12) College (1-4or 5+)	iiie.	DO NOT use retired)			Aret Manager	
א ס	filed Hygiv other		17. Father's Name (First, Middle, Last)		Manager	18. Mother's Nan	ne (First, Middle, I	Art Museum Maiden Sumame)	
Maryland	should be filed within 72 hours efter death with the Marylan and Mental Hydiene. **marked other then "naturel", or iteme 23a or 28a-f show umatic event, the Medical Examinar must be notified at	To Be	Alonzo Hussey			Irene V	Vilson		
2	shou nd M umat	-	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street an	nd Number or Ru	ral Route Number	, City or Town, State, Zip	Code)
ž	and 2 alth a 27 is		Thomas Butterbaugh Husband	719 M	Maiden Cho	ice Lane	e #BR316;	Catonville,	MD 21228
Baltimore,	permit. Peges 1 and 2 should be Dapartment of Heatlih and Mental Importent: If item 27 ie marked any injury or other traumatic evonce.		20a. Method of Disposition 20b. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	Place of Dispo	osition (Name of matory or other place))	Date	20c. Location - City or To	own, State
Ĕ	Peg ent: i			udon Pa	ark Cemete	ry 11/1	11/06 E	Baltimore, M	laryland
<u>a</u>	aperti sport y in		21. Signature of Funeral Service Licensee	22	2. Name and Address	of Facility Ste	erling As	hton Schwab	Witzke
	₫ O E € d		Jeples -		1630 Edm	ondson A	Avenue; C	lle, Inc. Catonsville,	
			23a. Part1. Enter the disease or complications that caused the deashock, or heart failure. List only one cause on each line.	ath. Do not ent	ter the mode of dying,	such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	d D	emen tio	2			Criset and Death
	/Medical Examiner		Due to (or as a conse	iquence of):					
		-	Sequentially list conditions, b. Due to (or as a conse	querne off;					
/	uted d ansit	Examiner	d any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events						
ó	ficate be executed physicien and is the burial-transit	Exa	resulting in death) Last	quence of):					
8760,	ate be nysicii he bu	dicai	d.						
õ	e as t	Med	IF FEMALE:						
Rox	eath certific ettending p	ian/	23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fell	tel death 3	Ectopic pregnancy			23d. Date of deliver	ery Day Year
o O	at the de by tha e teched f	Physician/Me	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of 9 ☐ Unknown	death 5	Other (specify)				
J.	res thet ti igned by be detec		Part II. Other significant conditions contributing to death but not re	sulting in the u	Inderlying cause given	in Part I.	23e. Did tot	pacco use contribute to the	ne cause of death?
Hecords,	luires sign lld be	d by	Anorexia				1 □ Ye	es 2 No 3 Prot	pably 4 Donknown
ဂ ္ဂ	w requir s been si should I	iete	Preumonia				24a. Was a	n 24b. Were auto	psy findings available
ř	sicien: The law requires that the death certificate be executed certificate has been signed by the attending physicien and irector, page 2 should be deteched for use as the burial-transit	Completed	- regerative				autops perforr	y prior to co	psy findings available mpletion of cause of
		Bec	25. Was case referred to medical examiner?			26. Place of Dea	th (Check only on		20140
<u> </u>	Physic this ce al dire	10	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatier		4 Nursing	lome 5 Reside	ence 6 Other (Specif	iy)
Ĕ	ding Ph th. After th funeral	ü	27. Manner of Death 1 ☑Naturat 5 ☐ Pending 28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Work?		28d. Describe ho	w injury occurred	
SIC	uttendi death. ctor: A y the fu	cat	2 Accident investigation 3 Suicide 6 Could not be 200 Bloom of Injury Atl	h		es 2 No	004		
Division of	after after Direction by	Certification:	4 Homicide determined 28e. Place of Injury - At 6 building, etc. (Spec	ify)	reet, factory, office		City or Town	reet and Number or Rura n, State)	il Houle Number,
	To the Hospital or Attending Physicien: within 24 hours after death . To the Funcasi Director: After this certific completely filled in by the funeral director,	Medicai C	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my kr 2 Medical Examiner: On the basis of examinand manner stated.	nowledge, deat nation and/or in	th occurred at the time	o, date and place nion, death occu	, and due to the carred at the time, d	ause(s) and manner as s ate and place, and due to	tated. the cause(s)
	Vithin Fo the	Me	29b. Signature and title of certifier		29c. License	number	2	9d. Date signed (Month,	Day, Year)
	. , , ,		Denes Bonds	· mn	1000	377		11/8/06	
	7/		30. Name and address of person who completed cause of death (Ita		Print) Denee	n Bow	lin, mr)	
	0		711 Mouden Choice have,	11	11 -				
	Sta Registr	_	31. Date filed (Month, Day, Year) NOV 0 9 2006 32, Registrar's Sign	nature	mels .				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 28, **Physician** 2006 6:13 AM M Zachary Burbank /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Bel Air Upper Chesapeake Med Ctr HUnder 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. Oct 28, 2006 9. Birthplace (State or Foreign Country) Maryland 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1⊠M 2□ F Director none Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County if item 27 is marked other then "naturel", or items 23a or 28a-1 show or other traumatic event, its Medical Examinar must be notified at 1 ☐ Yes 2√ No by Funeral Director Virginia Beach 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 3208 Scarborough Way 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2∑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1™ Never Married 2 Married white Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) none none none none 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Sumame) Be Bryanna Sicilano 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 500 Upper Chesapeake Drive Bel Air, MD Upper Chesapeake Med Ctr altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ē 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State important: If any injury or once. 4 □Donation 5 🛣Other (Specify) in state 21. Signal and Funeral Service Licensee Ron Id S. Wad., Director State Anatomy Board 655 W. Baltimore Street 1 Club Baltimore, MD 21201 23a. Part \(\) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ihr par 22 meens Enysician pvc-madrid resulting in death) /Medical Due to (or as a consequence of): Examiner Charloumionitis Saquentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transi The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
153Live birth 2 ☐ Fetal death
4☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 10 2006 28 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 1□Yes 2√JM6 3 Probably 4 Unknown Burbank, Zachan 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 21 No 1 Tes nerei Director: Alter this certific filled in by the funeral director. 25. Was case referred to medical 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No 173 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 5 Pending investigation Injury 1 Yes 2 No death. 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours e To the Funerei C completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 060444 10/29/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) north Are Stite you acl 1 is no 21014 Chunin Leur 76 32. Registrar's Signature 31. Date filed (Month, Day, Year) State TO ALLES 0 9 2006 Registrar

M 800378261

		For State Registrar	State of Man		epartmen Certificat					Reg. No.	400		371
Physicia /Medica	n al	Decedent's Name (First, Middle, t LELIA BAKER		-		-		r	Date of De Month	BER,	Yea County of De	500 15:	of Death
Examine		4a. Facility Name (If not institution, g	HUSPITA	In yrs. last birt	BA	Clin	Location of	9 0	Date of Bir		N/A		e or Foreian
Funeral Director		214-18-6930 Usual Residence of Decedent	1□ M 2ŪXF	87	Yrs. Months	Days	Hours	Min,	Date of Bir (Month, Da 6–12–	19. Year) -1919) VI	Birthplace (Stat Country) [RGINIA	
e Marylan	ctor	MD . 10b. County N/A	1	Oc. City, Town	IMORE							1 ∑ Y	City Limits
or 2	Dire	10e. Street and Number			10f. Zip					10g. Cit	izen ol What	Country?	
ath v	rai	2537 W. PRATT	ST .	ar in II C		21223		in? /Space	tu Vac ar Na	. I	USA	merican Indian	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: if Item 27 is marked other than "nature!", or Itema 23a or 28a-1 show eny injury or other traumatic event, the Madical Examinar must be notified at once.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Forces?		13. Was Deced If Yes, spec		Specify:	Puerto Ri	can, etc.)		Black, W Specify: I	hite, etc.	
Madical	pjeted	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education trade completed) College (1-4or 5+)		Decedent's Usua (Give kind of wo life. DO NOT us	al Occupa rk done d se retired)	ition luring most)	of working	1	16b. K	ind of Busine	ss/industry	
Hygien other the	PO.	-12-	-0-	C	HAMBER 1	1AID				l	HOTEL		
Mental Hy arked otheric event,	To Be	17. Father's Name (First, Middle, La	st)					,	First, Middle FLACKS		Sumame)		
n 27 ie mu ar traum		19a. Informant's Name/Relationship SAMUEL BREVARI	(SON)		Mailing Address	EENBE		RD. P	TAHWO	CAN,	VIRGI	NIA 231	39
nt: if iten ry or oth		20a. Method of Disposition 1X Burial 2 Ø Cremation 3 4 □ Donation 5 □ Other (Spe	Removal from State	cemeter	Disposition (Nary, crematory or c	ne of ther place		Da 1–9–2				or Town, State E, MARY	LAND
importa eny inju once.		21. Signature of Funeral Service Lice	ensee JONATHAN	D. HIB								Æ, P.A RYLAND	
nysician		23a. Part / Enter the disease, or co show or heart lailure. List on Immediate Cause (Final disease or condition			not enter the mod				_			Approxin Interval I Onset ar	Between
ysicie he bur	edicai Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause juisease or injury that initiated events resulting in death) Last	b. Due to (or as a control of the co	consequence (of):								
by the ettending phystached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 l 4 □ Pregnant at tin 9 □ Unknown	Fetal death	3 □Ectopic pr 5 □ Other (sp						23d. Date of Month	delivery Day	Year
		Part II. Other significant conditions	contributing to death but i	not resulting in	n the underlying o	ause give	en in Part I.			tobacco i Yes 2	/	to the cause of Probably 4	
sete has been s page 2 should	Completed							_	24a. Was auto perfe 1 Yes	psy ormed?	prior death		gs available if cause of
certifi	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient	2 ☐ ER/Ou	tpatient 3 D	Othe	٠ <u>-</u>		Check only		6 □Other (S	pecify)	S VISA
Afte		27. Mannur of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date of Injury (Month, Day Y	28b. 1 Year) li	Firme of 2 njury M	Bc. Injury Work 1 🔲 \	rat ⟨? Yes 2		d. Describe	how inju	ry occurred		
within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could no 4 Homicide determin	28e. Place of Injury building, etc.	y - At home, fa (Specify)	rm, street, lactor	, office		28	II. Location (City or To			Rural Route N	umber,
Hours at Fours	Medical	29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the best of a aminar: On the basis of ea and manner state	xamination an	e, death occurred d/or investigation	at the lim , in my op	e, date and pinion, deat	d place, ar h occurred	d due to the I at the time,	cause(s date and) and manner d place, and c	as stated. due to the caus	e(s)
To the within 2 To the complet	ž	29b. Signature and title of certifier				. License						onth, Day, Year	
		30. Name and address of person wh	11211	ath (Item 23a)	(Type, Print)	P-	F11P-	0		Novi	ember	205,	2006
Stat Registra		YASMIN AU 31. Date filed (Many Day, Year)	106 32 degistrar	s Signature	700	ATO	NA	JENI	JE, B	ALT	imore	Carr P.	2122

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Of Certificate of Death

				State of Marylan		te of Death	Reg.	2000	35375
	51 :		1. Decedent's Name (First, Middle, Last) /	(- 1 11 1	2. Date of Death Month	Day Year	3. Time of Death
A Super	Physici /Medi		lErAh	1100	Come		OCTOBER	31 200	6 4:05pm
1	Examir		4a Facility Name (If not institution, give	1.1	HOME	4b. City, Town, or	Location of Death	3 Alt	
			5. Social Security Number 6. Se	YTHERAN x 7. Age (In yrs.		r 1 Year If Under 24 Hrs	S. 8. Date of Birth		
3	Funeral Director		374344553 10	DM 200 F 7	3 Yrs. Months			1933 TEN	rthplace (State or Foreign country) 10 E 55 E/E
	mc m		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Location				10d. Inside City Limits
	a-f sh	ctor	MB BAltim	ORE U	INDSOR	mill			1 ☐ Yes 2 No
	with the	Funeral Director	10e. Street and Number	#1)	10f. Zip	Code	10g.	Citizen of What C	ountry?
	Seath Tre 23	era	1) (i) ER 7)	12. Was Decedent Ever in U Armed Forces?	,S. 13. Was Dece	dent of Hispanic Origin? (S cify Cuban, Mexican, Puer	Specify Yes or No-	14. Race - Am	
020	is 1 end 2 should be filed within 72 hours after death with the Marylend of Health end Mentel Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at	by Fun	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 █ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	If Yes, spe		rto Rican, etc.)	Specify: B	ite, etc.
5-0	72 ho	eted	15. Decedent's Edu (Specify only highest grad	ication le completed)	16a. Decedent's Usu (Give kind of wo	al Occupation ork done during most of wo se retired)	orking 161	b. Kind of Business	s/Industry
21215-0020	within ane. than	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)	3 .	'iAN			School
	filed with I Hygiene. other than	Be Co	17. Father's Neme (First, Middle, Last)	1	1 11		me (First, Middle, Mai		C / 3
Maryland	2 should be end Mentel is merked o	ToB	LUN PREST	on W	hittEN	Annie	BEAT	RICE	Smith
Mar	id 2 should th end Men 7 is marke traumetic		19a. Informant's Name/Relationship (T)	Print) COMEGY	19b. Mailing Address	s (Street and Number or R) ナメーア/世门	iural Route Number, C W *NDSA	- 4 -	Zip Code)
ore,	permit. Pegas 1 end Depertment of Health Important: if Item 27 any injury or other tr once.		20a. Method of Disposition 1 Burial 2 Cremation 3 D	20b. F	Place of Disposition (Na cemetery, crematory or	me of		. Location - City or	1. 200
Baltimore,	. Pegas Imant of I tant: if ite jury or o'		4 □ Donation 5 □ Other (Specify,	67	EEN MOUR	of CEM	11-1-06 B	Altimo	710
Bal	permit. Peg Depertment important: if any injury o		21. Signature of Funeral Service Licens	11/1 03	22. Name ar	nd Address of Facility 3	4316-01-2	ERS+B	Alto MAD 2/2/3
	-		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o	lications hat caused the deat	th. Do not enter the mix	P A WEATH de of dying, such as cardia	AFRITORD ac or respiratory arrest	F/3 PA	Approximate
	Physician		shock, or heart failure. List only o	ne causé on each line.					Interval Between Onset and Death
7	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	RESPIRATO	DRY FAIL	URE			
		<u>ة</u>	, rooming in docum,		or as a consequence of).		A.a	Dec	
	cuted	Examiner	Sequentially list conditions,	b. Methecillin Due to (c	or as a consequence of):	Staphyloco	OCCUS FILLE	505 MOU	monia
90,	oe axe cian e ouriel-l	Ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c					
68760,	physics the t	edicai	that initiated events resulting in death) Last	Due to (c	or as a consequence of):				
Box (nding use e			d					1
	death	Physician/N	Part II. Other significant conditions co	ntributing to death but not res	sulting in the underlying	cause given in Part I.	23b. Did toba	cco use contribut	te to the cause of death?
P.0	The law requiras that the death certificate be asscuted ate has been signed by the ettending physician end pege 2 should be detached for use es the bunet-trensit						1 □ Yes	2 □ No 3 □ F	Probably 4 Unknown
Records,	w requiras that been signed t should be det	d by					24a. Was an a	utopsy 24b.	Were autopsy findings
000	w req	Completed					performed	1?	available prior to completion of cause of death?
	The law te has pege 2	E					1 ☐ Yes	218No	1 □ Yes 2 □ No
of Vital	i cia n: The cartificate ractor, peç	Be	25. Was case referred to medical examiner?			A District	eath (Check only one)		
€	Physician: this cartific ral diractor,	2	1 ☐ Yes 2 ☐ No		ER/Outpatient 3□ D		Home 5 Residenc		ecity)
	ding P. After I	tlon:	27. Manner of Death 1 □Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how	injury occurred	
Division	Attending or deeth.	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, factor	y, office	28f. Location (Stree City or Town, S		Rural Route Number,
٥	urs after rai Dir	Cer							
	To the Hospital or Attending Physician: The I within 24 hours after deeth. To the Funeral Director: After this cardificate ha completely filled in by the funeral director, pege	edicai	29a. Certifier (Check only one) Certifying Phy Certifying P	siclan: To the best of my kno ner: On the basis of examina and manner stated.	wiedge, death occurred ition and/or investigation	at the time, date and plec n, in my opinion, death occ	e, and due to the caus urred at the time, date	e(s) and manner a and place, and du	is stated. le to the cause(s)
_	Vithin To the	Me	29b. Signature and title of certifier		29	c. License number	29d.	Date signed (Mon	nth, Day, Year)
J			Millrah Stewe			142931	1	DV6MD5Y	1,2006
_	1/		30. Name and address of person who co	ompleted cause of death (Iter 7220 PA/U	n 23a) (Type, Print) CHEIGHTS A	H45931 VENUE BAH	hmare M	10 2120	8
	Sta		31. Date filed (Month, Day, Year)	32 Registrar's Signa					

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Reg. NG 006 35376 1 - State Registrer Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Oct. 17, Day 2006 Year **Physician** 12:37pm Farangis Changizi /Medical 4c. County of Death 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore University of MD Medical Ctr. Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | Min. | March 22, 1947 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 ☐ M 2√2 F 59 693-01-7545 Iran Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 7 is marked other than "naturel", or itsms 23s or 28e-1 show treumstic event, the Madical Examinar inust be inclified at 1⊞Yes 2□No Director VA Alexandria 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 5405 Duke Street # 203 22304 death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 2 should be filed within 72 hours after and Mental Hygiene. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 X Married Specify: Persian Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Ď 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Home Maker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Rezullunah Changizi Baghech Changizi 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) s 1 and 2 s if Health an item 27 is 5405 Duke St # 203 Alexandria, VA 22304 Ezatollah Fanaeian 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition permit. Pages 1
Department of Hi
Important: If ites
any injury or oth 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
'4 ☐ Donation 5 ☐ Other (Specify) National Memorial Park 10/20/2006 Falls Church, VA 22. Name and Address of Facility National Funeral Home 7482 21. Signature of Funeral Service Licensee Drawa Z Louney Lee Highway, Falls Church, VA 22042 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 6 years Coronary Artery Disease /Medical Due to (or as a consequence of) Examiner Myocardial Infarction 6 years Sequentially list conditions, if any, leading to infimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to for as a gunsiaciones of). Examiner attending physicien and for use es the burial-transit The law requires that the death certificate be executed **Heart Failure** 3 days Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 XNo Day 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 Tyes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 Yes 2 No Hospitel or Attending Physicien: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ★npatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 € No this 28a. Date of Injury (Month, Day Year) After th 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: / 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide within 24 hours after To the Funerel Dire completely filled in b 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the Vithin 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 61052 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE MD. 225. GREENE VIGILANCE DEON 31. Date filed (Month, Day, Year) State NOV 0 9 2006 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No2 0 0 6 Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Dete of Deeth 3. Time of Death OCT. Physician 30 2006 01:15 AM Stuart Creek /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Neme (If not institution, give street and number) Examiner Specialty Hospita Baltimore If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 5. Social Security Numb 6. Sex 8. Date of Birth (Month, Dey, Year) **Funeral** Days Hours 10M 20 F Yrs. Director 218-80-8872 Apr 25, 1961 Maryland Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 DXYes 2 □ No Director N/A **Baltimore** Maryland 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 229 North Mount Street -306 21223 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? filad within 72 hours aftar Hygiana. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give 21215-0020 1 ☐ Yes 2 ☐ Nio Specify: Specify: Black Completed by 3 Widowed 4 Divorced Year or Dates: 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) Self Employed Hiome Improvement 12 permit. Pagas 1 and 2 should be file Dapartmant of Haatih and Mantal Hy important: If flem 27 is marked oths any injury or other traumatic event, once. Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be Shirley Creek Vernon Creek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 229 North Mount Street- 306 Baltimore, Maryland 21223 Shirley Creek Baltimore, 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □8urial 2 □ Cremation 3 □ Removal from State 11/04/04 4 ☐ Donation 5 ☐ Other (Specify) Windsor Mill, Md. King Memorial Park 21. Sign of Funeral Service Lice see 22. Name and Address of Fecility Estep Brothers Funeral Service, P. 1300 Eutaw Place Baltimore, Md 21217 23a. Part. Ent. the sease, or complications that caused the deeth. \D. In the enter the mode of dying, such as cerdiac or respiratory arrest, shock, or deart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical PNEUMO THORAX 2 Mon THS Examiner Due to (or as e consequence of): Examiner attanding physician and for usa as tha bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical Due to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 □ Probably 4 Unknown 1 ☐ Yes 2 ☐ No umuno DEFICIENCY VIRUS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy ANEMIA performed' 2 No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 25 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Aftar thi 28e. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Afcomplataly filled in by the fun daath. investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 6 the Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the ceuse(s) and manner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. edical 29a. Certifier (Check only 29b. Signature end title of certifier D61765 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) QUAINOD WY SSSO WILKERS AVE #307 BACTIMORE IND

DHMH 16 Rev 6/95

State Registrar 31. Dete filed (Month Day

のス

 $\boldsymbol{\omega}$

32 Registrer's Signature

2006

Boards

Please Type or Print in Black Indelible Ink

ncir	ne Clark		Sta 1- For State	ate of Maryland		artment of rtificate of		and	Menta	l Hyg		20	106	3537
	Physici	an/	Registrar 1. Decedent's Name (First, Middle	(Last)		remodelo or	200011				Date of Dea		3. Ti	me of Death
edic	al Exami		FRANCINE C	CLARK						١	Month Novembe	Day Year r 6, 2006	0:	203 hrs
in September 1			4a Facility Name (if not institution			4	b. City, Tov		ocation of D	Death		4c. County o	Death	
			St. Agnes Hospital	17.	,, ,		Baltimo		wit. a o	- Io	Data of D	N/A	O Burbulas	- (61-1-
	Funeral Director	1	,			last birthday)	If Under	Days	If Under 2 Hours	Min		rth (MM/DD/YYYY)	Foreign	
	Director		210 02 0001	1 M 2 K F	57	Yrs					11/10	0/1948	Country)	Md.
	пу		Usual Residence of Decedent 10a State 10b County		10c. City	, Town or Location	on						10d	Inside City Limits
	d how a	_	MD N/A			Baltim	ore						1 🕸	Yes 2 No
	Maryland 28a-f show any d at once.	cto	10e. Street and Number				10f, Zip C	ode			1	10g Citizen of Wha	at Country?	
	vith the Maryland s 23a or 28a-f show notified at once.	Director	24 BenKert Av	zenije			212	29				USA		
	with us 23, be not	uneral	11. Marital Status	12. Was Decedent	Ever in U		Decedent	of Hispa			fy Yes or No	14. Race	American Ir	idian, Black,
	death or iter must	Ë	1 Never Married 2 Ma	1 Yes 2	X No	IT YE	s, specify (Juban, I	viexican, P	ueno Ric	an, etc.)	White	etc.	
	after rat".	by F		orced If Yes, Give Year or Dates:			Yes 2X	-				Specify		ack
	hours natu		15. Decedent's Education (Spec			16a Decedent during mo	s Usual Oc st of working					16b. Kind of Bus	iness/Indust	гу
36	in 72 han "	bet	Elementary/Secondary (0-12) 12	College (1-4 or 5)+)	Nurse						Balto	City	Health
ô	d with	Completed	17. Father's Name (First, Middle, I	Last)		Nurse	•	18	3.Mather's I	Name (Fi	rst, Middle,	Maiden Surname)	City	TICAL CI
21215-0036	be file htal H	Be	Roderick Har	ndy					Mari	.e	Hand	y		
21	d Mer s mar	ု	19a Informant's Name/Relationsh			19b. Mailing	Address	(Street a	and Numbe	er or Rura	al Route Nu	mber, City or Town	, State, Zip 0	Code)
QW W	permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		Donna William	ns	Las							ore, Md.		
ē	s l ar of Hez If ite		20a Method of Disposition 1 X Burial 2 Cremation	3 Removal from Sta		Place of Disposi crematory or oth		of ceme	etery,	U	ate	20c. Location -	City or Town	State
Baltimore,	Page ment fant: or ot		4 Donation 5 Other Spe	ecify:	_ Mt	. Zior	Cem	ete	ry 1	1/1	4/20	d6Balti	more.	Md.
3alt	ermit Depart mpor njury	de	21 Signature of Funeral Service L	xcensee // /	Do De	22. NEST	eme and Ac	${ m rot}$	of Facility : hers	Fu	nera	1 Home		
		1	3a. Part I anter the disease, or	omplications that cause	the death	130	O Eu	taw	Pla	iac or re	Ba1	timore.	Md.2	1217 proximate Interval
	hysician Medical		failure List only one cause of	on each line.		1/		-,			,		Be	tween Onset and Death
=	xaminer		Immediat Cause (Final disease or condition resulting in death)	a. Chronic Obstruct			ease	_						
			Sequentially list conditions,	b. Hypertensive At	herosc	lerotic Cardio	ovascula	r Dise	ase					
		iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	quence c	of):								
	_	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence c	of):								
٦ (e be executed ysician and burial - transit	a E		d										
ó	e be ex ysician burial	edical	UNPENDED	AMENDED										
376(ficate g phy s the b		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome 1 Live birth	ne of preg	-	al death	3	Ectopic p	regnancy	,	23d. Date of o	delivery Day	Year
Box 6876	h certi tendin use a	icial	past 12 months?	4 Pregnant at	time of de	ooth	er (Specify	_	Lotopio	rogi idi ioy		, , , , , , , , , , , , , , , , , , ,	Day	700.
Bo	e deat the at ied for	Physician/N	1 Yes 2 No 9 V Unki	9OHKHOWH										
P.O.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	by P	Part II. Other significant condition	ons contributing to death	but not r	resulting in the u	nderlying ca	ause giv	ren in Part			obacco use contrib	_	
	quires en sign									_	24a Was			findings available
oro	aw rec nas bec 2 shou	Completed								_	auto	psy pr		etion of cause of
Rec	The cate page	5									1 Yes	2 V No 1	Yes	2 No
Division of Vital Records,	fing Physician: The After this certificate I funeral director, page	a	25. Was case referred to medical examiner?	Haenital		ER/Outpatient			ther ₄	heck only Jursing H		Basidanas 6	Other:	
>	Phys er thi	<u>۽</u>	1 Yes 2 No 27. Manner of Death	1 Inpatie		28b. Time of Ir		` _	at Work?		-	Residence 6 how injury occurre	-	
o uc	nding th r: Aft ie func	, <u>E</u>	1 V Natural 5 Pendi	(Month, Day,Ye	ear)				s 2 N			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
isi	r Atte er dea recto	ig		tigation 28e. Place of Inj	ury - At h	ome, farm, stree	t, factory, o	ffice bui	ilding, etc.	28	f. Location (Street and Numbe	r or Rural Ro	ute Number, City
Š	To the Hospital or Attent within 24 hours after death To the Finneral Director: completely filled in by the	Certification:		mined (Specify)							or Town,	State)		
	Hosp 24 hor Fune tely fi		20a Cortifier	ysician: To the best of my	/ knowled	dge, death occurr	ed at the ti	me, date	e and place	e, and du	e to the cau	se(s) and manner	as started	
	To the Hos within 24 h To the Fun completely	Medical		miner:On the basis of exar and manner stated	nination a	and/or investigati	on, in my o	pinion, d	death occu	rred at th	e time, date	and place, and du	e to the caus	se(s)
	- > - >	ž	29b. Signature and title of certifier				í	icense				29d Date signe		ay, Year)
	4		anes 2	<u> </u>				O.C.M	.E.			November 7	7, 2006	
	7		30. Name and address of person			·	hast D	IAI	- 140.0	1204				
			01.0-1-1-1-1	istant Medical Exam		111 Penn S	A . b		e, MD 2	1201				
	S	tate	31. Date filed (Month, Day Year)	9 200 32. Registral	s Signati	ure J.	roule							

			For State Registrar	State of Marylar	nd / Department of Healt Certificate of Dea		Reg. No	. 0 0 0	35379
			Decedent's Name (First, Middle,	Last)			Date of Death		3. Time of Death
	Physici /Medio		NETTIE L (ChANEY		~	Month Da	Year Zool	6 123 AM
	Examir		4a. Facility Name (If not institution,	give street and number)	4b. City, Town, or Locati	tion of Death	40	. County of Dear	th
			Future	Care - A	last birthday) If Under 1 Year If Un	nder 24 Hrs. 8	Davis of Dist	~//	7
	Funeral Director		5. Social Security Number	6. Sex 7. Age (In yrs.	Yrs. Months Days Hou	ırs Min.	Date of Birth (Month, Day, Year,		thplace (State or Foreign buntry)
			Usual Residence of Decedent				50142 1	16/1	a against
	rylan	_	10a. State 10b. County	10c. Cit	ty, Town or Location				10d. Inside City Limits
	Be-f	cto	ma	10/1	Palter	noce			1 Yes 2 □ No
	with th	DI.	10e. Street and Number	DADN PI-	10f. Zip Code	n 9	10g. Ci	tizen of What Co	ountry?
	eeth	Funeral Director	11. Marital Status	12. Was Decedent Ever in U	J.S. 13. Was Decedent of Hispanic	c Origin? (Specify	Yes or No-	14. Race - Ame	erican Indian.
36	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other then "netural; or Items 23a or 28s-f show spir injury or other treumatic event, the Modical Examinar must be multised at ance.	þ	1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed Forces?	If Yes, specify Cuban, Mex 1 ☐ Yes 2 ☐ Ne. Specify	xican, Puerto Rica	in, etc.)	Black, Whit	
21215-0036	72 hou	Completed	15. Decedent's (Specify only highest	Education	16a. Decedent's Usual Occupation (Give kind of work done during r	most of working	16b. K	(ind of Business/	Industry
2	ithin 7	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)	/	1 6	salto	. city
	filed w Hygier other th		17 Fatharia Nama (First Middle)	NIA		dian along (5	ant Middle Maide	Chow(> your
and	d be fi	Be	17. Father's Name (First, Middle, La	a NI BA	18. M	others Name (F)	rst, Middle, Maider		010/
Maryland	should be and Mental marked o	ည	19a. Informant's Name/Relationshi	p (Type, Print)	19b. Mailing Address (Street and Nu	umber or Rural Ro	te Number, City	or Town, State, 2	Zip Code)
	and 2 sealth ar n 27 is	١,	Better Cha	nen - daughte	1 722 Yale Art	Bal	to, nd	. 21	229
altimore,	of Heal	1	20a. Method of Disposition	1	Place of Disposition (Name of cometery, crematory or other place)	Date		ocation - City or	1
Ë	Pages nent of int: If it iry or o		1 DBurial 2 Cremation 3 4 Donation 5 Other (Spe	3 Hemoval from State		p 11/9/2	2006 60	unel,	, md1
Balt	permit. Page Department important: If eny injury o		21. Signature of Fin eral Service U	bonsos	22. Name and Address of Fa	acility TARCH F	14 270	FREDH	LTO MD 21229 ILTEN PASS
			23a. Parti. Enter the disease, or conshock or learn failure. List or	omplications that caused the deat	th. Do not enter the mode of dying, such				Approximate Interval Between
,	Physician		Immediate Cause (Final disease or condition	D	EMENTIA				Onset and Death
	/Medical		resulting in death)	Due to (or as a conseq	quence of):		1		
н	Examiner		Sequentially list conditions.	b	HTN HYPE	MIEN	31m		
	ed slt	liner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	quence or):				
	and and al-trar	Examin	that initiated events resulting in death) Last	c. Due to (or as a conseq	quence of);				
8760,	ficate be executed physiclen and is the burial-transit	dical		d					
9	tificat ig phy as the								
Box	death certifi e ettending id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta				23d. Date of deli	
0.	0 0 0	Sici	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant at time of d 9☐ Unknown	feath 5 Other (specify)			Month	Day Year
٦.	hat ih ed by detach			s contributing to death but not res	sulting in the underlying cause given in Pa	Part I	23e. Did tobacco	use contribute to	the cause of death?
Vital Records,	law requires that the es been signed by th 2 should be detache	d by					1 ☐ Yes 2		
ខ្ល	w require s been sign	Completed					24a. Was an	24b. Were au	topsy findings available completion of cause of
ž	0 5 0	E O					autopsy performed2 1 ☐ Yes 2 ☑ No	death?	V
II	ician: Th certificete rector, pag	BeC	25. Was case referred to medical examiner?		26. PI	Place of Death (Ci		12.00	*
<u></u>	d is	10	1 Yes 2 No			Nursing Home	5 Residence	6 □Other (Spec	cify)
C	ding Pt h. After th funeral	on:	27. Manner of Death 1 ⊠Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of linjury at Work?		Describe how inju	y occurred	
=	ath or: /	cat	2 ☐ Accident investiga		M 1 ☐ Yes 2		Location (Street ar	d Number or Du	and Boute Mumber
<u> </u>	# Sept	-	3 Suicide 6 ☐ Could no	1 DB Dines of lainer At he	ama form streat frater, office	201.	City or Town, State	id Number of Au	rai Houte Number,
Division	i or Atte after de Directo	ertifi	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, street, factory, office fy)		,	,	
DIVISIO	Hospital or Atte	ical Certification;	4 Homicide determin 29a. Certifier 1 Oertifying (Check only 2 Medical Ex	building, etc. (Specification of the best of my kno xaminer: On the basis of examina	ome, farm, street, factory, office y) owledge, death occurred at the time, date tition and/or investigation, in my opinion, o	e and place, and	due to the cause(s)	and manner as	stated. to the cause(s)
DIVISIO	o the Hospital or Attendi ithin 24 hours after death. o the Funeral Director: A empletely filled in by the fu	Medical Certifi	4 Homicide determin 29a. Certifier 1 Certifying	building, etc. (Specify Physician: To the best of my kno	bwledge, death occurred at the time, date	e and place, and death occurred a	due to the cause(s)	and manner as	to the cause(s)
DIVISIO	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer		4 Homicide determin 29a. Certifier (Check only one) Check only 2 Medical Ex	building, etc. (Specification of the best of my kno xaminer: On the basis of examina	owledge, death occurred at the time, date tition and/or investigation, in my opinion, of the control of the con	e and place, and death occurred a per	due to the cause(s)	and manner as I place, and due te signed (Monti	to the cause(s)
DIVISIO	To the Hospital or Atte within 24 hours after de VID to the Funeral Direct Completely filled in by the		4 Homicide determin 29a. Certifier (Check only one) Check only 2 Medical Ex	Physician: To the best of my kno xaminer: On the basis of examina and manner stated.	owledge, death occurred at the time, date attorn and/or investigation, in my opinion, or 29c. License number 2000 16 9	e and place, and death occurred a	due to the cause(s) the time, date and 29d. Da	and manner as I place, and due te signed (Monti	to the cause(s)
DIVISION	To the Hospital or Atta		4 Homicide determin 29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and address of person with the company of the certifier	Physician: To the best of my kno xaminer: On the basis of examina and manner stated.	owledge, death occurred at the time, date attorn and/or investigation, in my opinion, or 29c. License number 2000 16 9	e and place, and death occurred a per	due to the cause(s) the time, date and 29d. Da	and manner as diplace, and due to signed (Month	to the cause(s)
DIVISION	To the Hospital or Atte. Within 24 hours alter de within 24 hours alter de within 25 hours alte	Medical	4 Homicide determin 29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and address of person with the control of the certifier 31. Date filed (Month, Day, Year)	Physician: To the best of my kno xaminer: On the basis of examina and manner stated.	owledge, death occurred at the time, date tition and/or investigation, in my opinion, of the last of the time, date at t	e and place, and death occurred a	due to the cause(s) the time, date and 29d. Da	and manner as diplace, and due to signed (Month	to the cause(s) 1. Day, Year) Lev L

			for State	State of Marylar	nd / Departme	nt of Health and ate of Death			35380
	- 101		Registrar 1. Decedent's Name (First, Middle, Las	sit)	Certifica	ne or Dearr	2. Date of Death	ı. No.	3. Time of Death
- 75	Physici		MILDER	V. CAG	ROLL		NOV.	Day Year 4 2006	12:00 NOOM
	/Medic Examin		4a. Facility Name (If not institution, give	4 /	1 4b. Gil	y, Town, or Location of Dea	ith	4c County of Death	
			540 N, AF 5. Social Security Number 6. S	FKEWOOD T. Age (In yrs.	HVE 13	ATIMORE Jer 1 Year If Under 24 Hr	S R Date of Righ	N/H	place (State or Foreign
	Funeral Director			□M 200 F 3	Yrs. Month			1923 MAR	intry) And
	p		Usual Residence of Decedent 10a. State 10b. County	100 A	ty. Town or Location		114/19	7-1	10d. Inside City Limits
	Aaryla Abov	or	Mal 100. county	1 3	111	DE			1 Yes 2 No
	r 28a-	rect	10e. Street and Number		10f. 2	Zip Code	109	. Citizen of What Cou	intry?
	23a o	Funeral Director	540 N. LA	KEWOOD H	VEI à	21205		U. S.H	7
	er des items	nue	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Eyer in U Armed Forces? 1 □ Yes 2 ☑ No	J.S. 13. Was Dec	cedent of Hispanic Origin? (becify Cuban, Mexican, Pue	Specify Yes or No- into Rican, etc.)	14. Race - Amer Black, White	
036	urs aft al', or	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes	2 No Specify:		Specify A	ek
1215-0036	within 72 hours after death with the Maryland ene. Than "netural", or ttems 23a or 28a-f ahow the Mardical Exemitier mittel be motified at	Completed	15. Decedent's Ed (Specify only highest gra			vork done during most of w	orking 16	b. Kind of Business/Ir	ndustry
121	within ene. then	ldmo	Elementary/Secondary (0-12)	College (1-4or 5+)	Po A tre	D. tu	Dis A	2 unte	Patients
2	filed wil Hygien other th	Be Co	17. Father's Name (First, Middle, Last)	Λ-	TRIVALE	18. Mother's Na	ame (First, Middle, Ma	iden Sumame)	1710113
ylar	should be nd Mental i marked o	To B	GEORGE	MURRAY	/	MAM	ÎE		
	C/ 42 = 6		19a. Informant's Nam elationship	0 11 77	1	ss (Street and Number or F	Rural Foute Number, C	City o Town, State, Zi	7/205
	tem 27		20a. Method of Disposition	ROIJONNSON	Place of Disposition (N cemetery, crematory of	LAKEWOOD	Date 20	c. Location - City or T	own, State
altimore,	Pages nent of int: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ 1 4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State	RRISM FAR	EST VETECEM	11/13/06 6	wingsh	nills my
alti	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Licen	500	32 Nama	and Address of Facility	Jon Es, JR	Fun. Si	IC. PA
20	20599		Diona les	and fine	18/4	N. BROAD	WAY /31	H to Mo	Approximate
			23a art1. Enter the disease, or compands, or heart failure. List only Immediate Cause (Final	one cause or cach line.	an. Do not enter the m	oue of dying, such as cardi	ac or respiratory arrest		Interval Between Onset and Death
17	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a consec	quence of):				tdays
7	Examiner		Sequentially list conditions,	6. Thisces					2-15
V	nsit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of);				
7	execu n and ial-trar	Examiner	that initiated events resulting in death) Last	Due to (or as a consec	quence of):				
3760,	death certificate be executed e attending physicien and id for use as the burial-transit	dicai	(d					
ž ×	entifica ding ph	/Med	IF FEMALE:	23c. If yes, outcome of pregn	ancy			604 5 4 4 5	
gox	leath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ ₩0	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o	al death 3 Ectopic			23d. Date of deliv Month	Pery Day Year
j Ö	to the de by the a tached f	hysi	9 Unknown	9□ Unknown					
s,	es tha	by	Part II. Other significant conditions o	ontributing to death but not res	sulting in the underlying	cause given in Part I.	23e. Did tobac	cco use contribute to t	the cause of death? bably 4 \(\subseteq Unknown \)
0.0	w requir been si should	Completed	- temes/15						
Ž	The law cate has page 2 s	mpi					24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of
-	(G LT	Be C	25. Was case referred to medical			26. Place of De	1 ☐ Yes 2 ☐ eath (Check only one)	No 1 ☐ Yes	2 No
> 10	Physic this ce	은	examiner? 1 Yes 2 No		E.VOutpatient 3 1		Home 5 Residence		(y)
uo o	ding F h. After funera	tion:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred	
DIVISION	Attendi	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined		ome, farm, street, facto		28f. Location (Stree City or Town, S	et and Number or Run	al Route Number,
5	ital or irs afte ral Dir led in								
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier 1 To Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my known the pasis of examination and manner stated.	owledge, death occurre ation and/or investigation	ed at the time, date and place on, in my opinion, death occ	e, and due to the caus curred at the time, date	se(s) and manner as s and place, and due t	stated. o the cause(s)
	To the within: To the comple	Med	29b. Signature and title of continer	1/2	2	9c. License number	29d	. Date signed (Month,	Day, Year)
			+ Tyle (406		H43157	_	11/6/06	
	٦.		30. Name and address of person who	TON	m 23a) (Type Print)	500 = QI	#20	md	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signi	ature ature	THER DO	- Calto	Inch	
	Registr	-	11012 0 0 2006	Region of B.	A COMPANY.		J		

DHMH 17 Rev 1/2001

			For State Registrar	State of Maryla		rtificate of			ZUUb	35381
18	DESCRIPTION OF	50	Registrar Name (First, Middle, Last))		rimeate or		2. Date of Death	g, No.	3. Time of Death
	Physic /Medi		Frances E. Cooke				/	North		6 12:45 PM
No. of State	Examii Funeral Director		213-16-3094	TOJ MEDICAL	S. last birthday)	Ci	If Under 24 Hrs. 8 Hours Min.	E 3. Date of Birth (Month, Day, 08-06-19	Year) Co	th PUNDEL Inplace (State or Foreign untry) MD
	/land low		Usual Residence of Decedent 10a. State 10b. County	10c. 0	City, Town or Lo	ocation		······		10d. Inside City Limits
	e Mary a-f sh iffied a	ctor	MD Anne Aru	ındel	Brookly	yn				1 □Yes 2 No
	or 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?
	eath v	Funeral	107 Haile Avenue	12. Was Decedent Ever in	118 13	21225		ify Ves or No.	U.S.A.	erican Indian
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if tem 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		If Yes, specify Cul 1 ☐ Yes 2 ☑ No	Hispanic Origin? (Speci pan, Mexican, Puerto Ri Specify:	ican, etc.)	Black, Whit	
5-0	"natu	Completed	15. Decedent's Educ (Specify only highest grade	cation e completed)	16a. Dece (Give	dent's Usual Occu kind of work done	pation during most of working ed)	7	6b. Kind of Business/	Industry
12	withir iene. than	dwo	Elementary/Secondary (0-12)	College (1-4or 5+)		il Sales		1	State of M	larvland
b	e filed al Hyg other	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name (
ylaı	ould b Ments arked	To	George Thomas Coo				Frances			
Mar	d 2 sh th and 7 Is m traum		19a. Informant's Name/Relationship (Ty)	,			t and Number or Rural			
ē	s 1 an f Heal tem 2 other		Mrs. Diane Garrity 20a. Method of Disposition	20b.	. Place of Dispo	sition (Name of	erley Circ		Son, MD 21 Oc. Location - City or	
Baltimore,	Pages nent o int: If I		1 Burial 2 □ Cremation 3 □ R □ Donation 5 □ Other (Specify)			matory or other pla en Mem. P	ark 11-09	-2006	Glen Burni	e. MD
3alti	epartn epartn nporta ny Inju		21. Signature of Funeral Service License		2:	2. Name and Addr	ess of Facility Sin	gleton 1	Funeral Ho	me, PA
	<u>₹</u> □ <u>=</u>		23a. Part1. Enter the disease, or compli	0000			ve SW; Gle			
	Dhysisian		shock, or heart failure. List only or immediate Cause (Final	ne cause on each line.				respiratory arres	st,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a conse	equence of):	Accid	ENT			2 days
N.	Examiner		Constant to the constitutes h	ATRIAL F	FARIL	ATION				months
			Sequentially list conditions,							
1	ted sit	niner	if any, Isaamg to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a const	equence of):					
()	executed in and ial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consci-	equence of):					
3760,7	ate be executed sysician and he burial-transit	ical Examiner	triat initiated events	Dué to (or as a const	equence of):					
× 68760,×	ertificate be executed ing physician and eas the burial-transit	edical	resulting in death) Last	Due to (or as a conse	equence of):					
Box	t the death certificate be executed by the attending physician and ached for use as the burial-transit	edical	resulting in death) Last	Dué to (or as a const	equence of): equence of): nancy etal death 3E	⊒Ectopic pregnand] Other (specify) _			23d. Date of del Month	ivery Day Year
P.O. Box	es that the death certificate be executed gned by the attending physician and be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 PNo 9 Unknown Part II. Other significant conditions com	Due to (or as a consection of the consection of	equence of): equence of): nancy stal death 3E death 5E	⊒Ectopicpregnanc] Other (specify) _	÷у		Month acco use contribute to	Day Year
P.O. Box	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 ENO 9 Unknown Part II. Other significant conditions con	Due to (or as a consection of the consection of	equence of): equence of): nancy stal death 3E death 5E	⊒Ectopicpregnanc] Other (specify) _	÷у		Month acco use contribute to	Day Year
P.O. Box	The law requires that the death certi ate has been signed by the attending tage 2 should be detached for use a	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 ENO 9 Unknown Part II. Other significant conditions con RENAL FAILURE Seps 15	Due to (or as a consection of the consection of	equence of): equence of): nancy stal death 3E death 5E	⊒Ectopicpregnanc] Other (specify) _	÷у	1 ☐ Yes 24a. Was an autopsy performe	Month acco use contribute to 2 ☑ No 3 ☐ Pr 24b. Were au	Day Year the cause of death? obably 4 Unknown ttopsy findings available completion of cause of
Vital Records, P.O. Box		Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 PNo 9 Unknown Part II. Other significant conditions con RENAL FAILURE SERS IS	Due to (or as a consection of the consection of	equence of): nancy stal death 3E f death 5E	□Ectopic pregnanc □ Other (specify) _ nderlying cause gi	ey ven in Part I. 26. Place of Death (contents)	1 Tyes 24a. Was an autopsy perform 1 Yes 2 Check only one)	Month acco use contribute to 3 2 No 3 □ Pr 24b. Were au prior to c death? 1 □ Yes	o the cause of death? obably 4 Unknown utopsy findings available completion of cause of
Vital Records, P.O. Box		To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 PNo 9 Unknown Part II. Other significant conditions con RENAL FAILURE SEPSIS 25. Was case referred to medical examiner? 1 Yes 2 PNo H	Due to (or as a consect. Due to (or as a consect.) 3c. If yes, outcome pf pregnant at time of 9 Unknown attributing to death but not reconstruction.	equence of): nancy stal death 3 [death 5 [esulting in the u	□Ectopic pregnanc □ Other (specify) □ nderlying cause gi	ey ven in Part I. 	1 Yes 24a. Was an autopsy perform 1 Yes 2 L Check only one) 5 Residen	Month acco use contribute to a 2 ☑ No 3 ☐ Pr 24b. Were au prior to a death? 1 ☐ Yes	o the cause of death? obably 4 Unknown utopsy findings available completion of cause of
Vital Records, P.O. Box		To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (of as a consection of the consection of	pagence of): nancy tal death 3E death 5E esulting in the u	□Ectopic pregnand □ Other (specify) □ nderlying cause given to 3□ DOA Other State	ey ven in Part I. 26. Place of Death (ther: 4 □ Nursing Home lands at the state of the state o	1 Yes 24a. Was an autopsy perform 1 Yes 2 L Check only one) 5 Residen	Month acco use contribute to 3 2 No 3 Pr 24b. Were au prior to c death? 1 Yes acco use contribute to to the prior to c death? 1 Yes acco use contribute to the prior to contribute to the prior to contribute to the prior to contribute to the prior to contribute to the prior t	o the cause of death? obably 4 Unknown utopsy findings available completion of cause of
Vital Records, P.O. Box		To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 ENO 9 Unknown Part II. Other significant conditions con RENAL FAILURE Sepsis 25. Was case referred to medical examiner? 1 Yes 2 ENO H	Due to (or as a consect. Due to (or as a consect.) 3c. If yes, outcome pf pregnant at time of 9 Unknown attributing to death but not reconstruction.	pagence of): equence of): nancy stal death 3E if death 5E ER/Outpatier 28b. Time o Injury home, farm, str	□Ectopic pregnand □ Other (specify) □ nderlying cause given to 3□ DOA Other State	ven in Part I. 26. Place of Death (other: 4 □ Nursing Homerry at trk? 1 Yes 2 □ No	1 Yes 24a. Was an autopsy perform 1 Yes 2 li Check only one) 5 Residen d. Describe how	Month acco use contribute to 3 2 No 3 Pr 24b. Were au prior to a death? 1 Ves acc 6 Other (Spear injury occurred	Day Year the cause of death? obably 4 Unknown ttopsy findings available completion of cause of 2 No cify)
P.O. Box		Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 ENO 9 Unknown Part II. Other significant conditions con RENAL FAILURE SCRSIS 25. Was case referred to medical examiner? 1 Yes 2 No H 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide Getermined	Due to (or as a consection) Due to (or as a consection) 3c. If yes, outcome pf preg 1 I Live birth 2 I Fe 4 Pregnant at time of 9 Unknown Intributing to death but not residual: 1 Inpatient 2 I 28a. Date of Injury (Month, Day Year) 28e. Place of Injury . At	paquence of): nancy stal death 3E death 5E esulting in the u ER/Outpatier 28b. Time o Injury home, farm, str	□Ectopic pregnanc □ Other (specify) □ nderlying cause given at 3□ DOA Other f 28c. Inju Wo M 1□ eet, factory, office	ven in Part I. 26. Place of Death (cher: 4 Nursing Homery at rk?] Yes 2 No 28	24a. Was an autopsy perform 1 Yes 2 li Check only one) 5 Residen d. Describe how	Month acco use contribute to 2 No 3 Pr 24b. Were au prior to cleath? 1 Ves 1 Other (Spect vinjury occurred set and Number or Rustate)	Day Year of the cause of death? obably 4 Unknown otopsy findings available completion of cause of 2 No cify)
Vital Records, P.O. Box	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director f	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions con RENAL FAILURE SEPS IS 25. Was case referred to medical examiner? 1 Yes 2 No 9 He determined 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide	Due to (or as a consection) Due to (or as a consection) 3c. If yes, outcome pf preg 1 I Live birth 2 I Fe 4 Pregnant at time of 9 Unknown outside the section of the sect	equence of): nancy stal death 3E f death 5E ER/Outpatier 28b. Time o Injury home, farm, str	Dectopic pregnanc of the courred at the to vestigation, in my	ven in Part I. 26. Place of Death (ther: 4 Nursing Home trk?] Yes 2 No 28: ime, date and place, an opinion, death occurred	24a. Was an autopsy perform 1 Yes 2 li Check only one) 5 Residen d. Describe how f. Location (Stre City or Town, and due to the caud at the time, dat	Month acco use contribute to 2 No 3 Pr 24b. Were au prior to cleath? 1 Ves 1 Other (Spect vinjury occurred set and Number or Rustate)	the cause of death? obably 4 Unknown stoppy findings available completion of cause of 2 No cify) wral Route Number, is stated. to the cause(s)
Vital Records, P.O. Box		Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consection of the basis of examina and manner stated.	pagence of): nancy stal death 3E death 5E BER/Outpatier 28b. Time o Injury home, farm, str	Dectopic pregnance of the control of	ven in Part I. 26. Place of Death (with the strict) at the strict and place, an opinion, death occurred se number	24a. Was an autopsy perform 1 Yes 2 li Check only one) a 5 Residen d. Describe how f. Location (Stree City or Town, at due to the cau dat the time, dat	Month acco use contribute to a 2 No 3 Pr 24b. Were au prior to a death? 1 Ves acc 6 Other (Spear injury occurred act and Number or Rustate) use(s) and manner as the and place, and due d. Date signed (Month)	the cause of death? obably 4 Unknown stoppy findings available completion of cause of 2 No cify) wral Route Number, is stated. to the cause(s)
Vital Records, P.O. Box	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director f	Medical Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consection of the basis of examina and manner stated.	pagence of): nancy stal death 3E death 5E BER/Outpatier 28b. Time o Injury home, farm, str	Dectopic pregnance of the control of	ven in Part I. 26. Place of Death (with the strict) at the strict and place, an opinion, death occurred se number	24a. Was an autopsy perform 1 Yes 2 li Check only one) a 5 Residen d. Describe how f. Location (Stree City or Town, at due to the cau dat the time, dat	Month acco use contribute to a 2 No 3 Pr 24b. Were au prior to a death? 1 Ves acc 6 Other (Spear injury occurred act and Number or Rustate) use(s) and manner as the and place, and due d. Date signed (Month)	the cause of death? obably 4 Unknown stoppy findings available completion of cause of 2 No cify) wral Route Number, is stated. to the cause(s)
Division or Vital Records, P.O. Box	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	Medical Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consection) Due to (or as a consection) 3c. If yes, outcome pf preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown Intributing to death but not reserve to the light of the light	pagence of): nancy stal death 3E death 5E BER/Outpatier 28b. Time o Injury home, farm, str	Dectopic pregnance of the control of	ven in Part I. 26. Place of Death (with the strict) at the strict and place, an opinion, death occurred se number	24a. Was an autopsy perform 1 Yes 2 li Check only one) a 5 Residen d. Describe how f. Location (Stree City or Town, at due to the cau dat the time, dat	Month acco use contribute to a 2 No 3 Pr 24b. Were au prior to a death? 1 Ves acc 6 Other (Spear injury occurred act and Number or Rustate) use(s) and manner as the and place, and due d. Date signed (Month)	the cause of death? obably 4 Unknown stoppy findings available completion of cause of 2 No cify) wral Route Number, is stated. to the cause(s)

1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Philip Clinedinst Jr. November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Burnie ANNE ARUNDEL BAltimore WAShington Medical Centre Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept.17,1922 **Funeral** Social Security Number 6. Sex 1X M 2□ F 7. Age (In vrs. last birthday) Months Days Hours Director 220-14-4456 84 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Important; If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Director MD Baltimore Dunda1k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8210 Long Point Road 21222 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? 1★1 Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married 1 ☐ Yes 2 No 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2 should be filed with and Mental Hygiene. Corpora1 U.S.Military of Health and Mental Hygi Item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Philip Clinedinst Elizabeth Ellison 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grand-Mrs. Angelina Wiseman/ daughter 1009 Elbridge Way Severn MD 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of I-14, XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Vets Cem. 2006 Crownsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral Home, 1 Second Avenue SW GLen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician 0 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner nevinon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) and -tra Due to (or as a consequence of) sician a P.O. Box 68760. The law requires that the death certificate be Physician/Medical physi the b as JE FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ Completed 1 ☐ Yes 2 ☐ No 24a. Was an autopsy page performed' hronic or Attending Physician: 25. Was case referred to medical examiner? Be

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

3 ☑ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 1□ Yes 2 1 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)

3. Time of Death

7:06 M

9. Birthplace (State or Foreign

10d. Inside City Limits

1 ☐ Yes 2 X No

2006

Black, White, etc.

White

Day

Year

10 h 6-

Registrar

P

Certification:

Medical

31. Date filed (Month, Day, Year) NOV 0 9 2006

29b. Signature and title of certifier

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

4 Homicide

(Check only one)

32 Registrar's Signature

Hospital:

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 ☐ Pending investigation

6 ☐ Could not be

determined

1 __Inpatient

28a. Date of Injury (Month, Day Year)

Medical

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

29c. License number

After

the 1

in by t

s after death.

To the Hospital of within 24 hours af To the Funeral D completely filled in

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** $2:30 p^{M}$ 2, 2006 NOVEMBER CARTER /Medical MURIEL 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE 3908 CHATHAM ROAD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🗓 F AUGUST 5, 1920 MD Director 86 212-20-3403 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Hoalth and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ?7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at YYes 2 No Director BALTIMORE MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21207 3908 CHATHAM ROAD Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 XI If Yes, Give Year or Dates: 1 Never Married 2 Married 2 🔀 No Baltimore. Maryland 21215-0036 1 ☐ Yes 2/√XNo Specify: Completed by 3 ☑ Widowed 4 ☐ Divorced BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **BCPS** TEACHER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SUSIE BOYER ျှ FRANK CONLEY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7266 MANDAN ROAD GREENBELT, MARYLAND 20770 ALGERIA TATE/COUSIN 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any Injury or o 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 11-09-06 GARRISON FOREST CEM. OWINGS MILLS, MD 4 ☐ Bonation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 1701-31 LAURENS ST. BALTIMORE, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequ Examiner The law requires that the death certificate be executed and burial-trar that initiated events resulting in death) Last Due to (or as a conseque Division or Vital Records, P.O. Box 68760, physician Physician/Medical the C, attending IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4 ☐ Pregnant at time of death 5 Other (specify) signed by the al 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2**/**No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No page 2 s has certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home A Residence 6 Other (Specify) 1 | Yes 2 | ₹No. 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Certification: To this 28a. Date of Injury (Month, Day 28b. Time of 28d. Describe how injury occurred funeral 27. Manner of Death 28c. Injury at Work? Year) or Attending 1 ZNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide completely filled in by 4 ☐ Homicide To the Hospital or within 24 hours aft To the Funeral DI 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed gause of death (Item 23a) (Type, Print) MUDN 31. Date filed (Month, Day, Year)

Registrar

State

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

			State of Maryland / Department of Certificate of Ce		Reg. No.	711116 7 16 7 17 17 17 17 17 17 17 17 17 17 17 17 1
			Decedent's Name (First, Middle, Last)	2. Da	te of Deeth	3. Time of Death
-	Physici /Medio		William Coleman	No	onth Day	
Ì	Examir		4a Fecility Name (If not institution, give street and number)	4b. City, Town, or Location Baltimore		County of Deeth
			THI Frankliw Square Health and Rehab 5. Social Security Number 6. Sex. 7. Age (In yrs. last birthdey) If Under 1 Yes		ate of Birth Jonth, Day, Year)	Birthplece (State or Foreign Country)
Н	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) If Under 1 Yee Also 5 7 Yrs. Months Day	s Hours Min. (M		49 Couintry) MD
	D &	'	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		1 -1 -	10d. Inside City Limits
	f aho	5				1X Yes 2 □ No
	28a	20	MD BALTIMORE 10e. Street end Number 10f. Zip Code		10g. Citiz	zen of What Country?
	th with	Funeral Director		229		USA
	e de la companya de l	n e		Hispanic Origin? (Specify Yoban, Mexican, Puerto Rican,	es or No-	 Race - American Indian, Black, White, etc.
20	I', or I	by F	1 1 1 1 Never Married 2 □ Married 1 □ Yes 2 1 No If Yes, Give 1 □ Yes 2 No If Yes, Give 1 □ Yes 2 No If Yes 2 No	Specify:		Specify: BLACK
Maryland 21215-0020	permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of health and Mental Hyglane. Important: If Itam 27 is merked other than "naturel", or items 23a or 28s-f show any injury or other traumette avant, the Medical Examiner must be notified at ance.	bet	15. Decadent's Education 16a, Decadent's Usual Occ	upation e during most of working	16b. Kir	nd of Business/Industry
2	Ithin 7	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	ed)		IONAMPHAMT ON
22	Part d	S	12 LABORER	18. Mother's Name (First		CONSTRUCTION Sumame)
au	d be f ental ?	To Be	ROBERT COLEMAN	PRISCILLA		· · · · · · · · ·
ary	shou and M amari	-		et and Number or Rural Rout		r Town, State, Zip Code)
Σ.	and 2 paith of n 27 is		MONTRA BROWN/SISTER 1017 KEVIN R			
ore	T of I		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ Removal from State	Pace)	e 20c. Loc	cation - City or Town, State
altlmore,	it Perturbant		4 Donation 5 Other (Specify) METRO CREMATORY 21. Signature of Funeral Service Licensee 22. Name and Add	11-8		TIMORE, MARYLAND
Ba	Department of many in the many is a second of the many				A. MORTO BALTIMOR	ON & SONS F.H., INC. RE, MD 21217
			23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dishoot, or heart failure. List only one cause on each line.			Approximate Interval Between
1	Physician		att. Married at 1850			Onset and Death
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Pue to (or as a consequence of):	FAILURE		
		je.	Due to (or as a consequence or):			
	ocuted ind transit	am	U.	···		
0	icete be executed physician and s the burlei-transit	edical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events Due to (or as a consequence of):			
68760,	The lew requires that the deeth certificate be exacuted tits has been signed by the attending physician and page 2 should be deteched for use as the buriel-transit		that initieted events resulting in death) Last Due to (or as a consequence of):			
×	anding use e	M	d			
B	he atte	Physician/N	Part II. Other significant conditions contributing to death but not resulting in the underlying cause (iven in Part I. 2	3b. Did tobacco	use contribute to the cause of death?
٦.	es that the deeth certific igned by the attending p be dateched for use es	Phy	MYOPATHY, AIDS,		1 Yes 2	□ No 3 □ Probably 4/区 Unknown
d S	algne d be	d by		24	ta. Wes an autops	sy 24b. Were autopsy findings
Š	w requ	Completed			performed?	available prior to completion of cause of deeth?
8	The less to hes	E O			1 □ Yes 2/2	No 1 □ Yes 2 □ No
<u>ra</u>	lan: 'a	Be C	25. Wes case referred to medical examiner?	26. Place of Death (Chec	ck only one)	
<u></u>	hysic this ce al dire	2	1 ☐ Yes 2 No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Nursing Home 5	Residence 6	
u O	Affer funer	ton:	27. Manner of Death 1万€Natural 5 □ Pending (Month, Dey Year) □ Accident investigation 1 M M M 1 1	ork? ☐Yes 2☐No	escribe now injury	, occurred
Division of Vital Records, P.O. Box	Attan ar deat actor: by the	Certification:	2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Lo	cation (Street and ty or Town, State)	d Number or Rural Route Number,
ā	rai or rai ofte rai Dir	5				
	To the Hospital or Attanding Physician: The lew require within 24 hours elect death. Of the Funeral Director: After this certificate hes been si completely filled in by the funeral director, page 2 should in the funeral director, page 2 should in the funeral director.	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the (Check only one) Medical Examiner: On the basis of examination end/or investigation, in my and manner stated.	time, date end place, and du opinion, death occurred at the	e to the cause(s) and time, date and	and manner as stated. place, end due to the cause(s)
	omple	¥	29b. Signature and title of certifier 29c. Lice	nse number	29d. Date	e signed (Month, Day, Year)
	4		Do	062634	1.	1/8/06
	nn		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	ace on Cat	15000.0	M A 2/
	+		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MATEEN AWAN (USO2 HICKORY RID 31. Date filed (Month, Day, Year) NOV 0 9 2006	45 20 600	017314 .	119 21044
	Sta Registr		NOV 0 9 2006			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TTFM/5 per FH, C866, 4/13/07 WS
State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Month Year LOREMA D. DARDEN 8:55 AM /Medical November 2000 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death UNION MEMORIAL HOSPITAL BALTIMORE NA If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Days | Hours | Min. (Month, Day, 5. Social Security Nu3525 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 👺 F 214. 50. 3535 Director 6 mo Usual Residence of Deceden with the Maryland 10a. State 10h County 10c. City, Town or Location 28a-f show 10d. Inside City Limits notified at Director MD BALTIMORE GWYNN 1 ☐ Yes 2 No OAK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 2 Examiner must be 2602 ROYAL OAK AVENUE 21207 Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23: USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BUACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) r than the Me Elementary/Secondary (0-12) College (1-4or 5+) 12TH GRADE NA **AUDITOR** RETAIL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 7 is marked traumatic e KOBERT HARDY ပ္ EVELYN TAYLOR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DONNETTA DARDEN (DAUGHTER) 823 MT. HOWY ST. other t BAUD. MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State = 5 Department of Important: If any injury or 4 □ Donation 5 □ Other (Specify) ARBUTUS 11-11-06 Baud, MD 21. Signature of Funeral Service Licen 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 5151 BAUD. NATU PIKE, BAUD. MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Coloni Cancer Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 11 months /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the death certificate be executed and burial-tra Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the as IF FEMALE: asn 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 9☐Unknown Month Day Year 5 Other (specify) P.O. ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Z Unknown Completed peen page 2 s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No certificate has autopsy performe 1□ Yes 2☑No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' To Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Z No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this uneral 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28b. Time of After 28d. Describe how injury occurred Hospital or Attending 24 hours after death. Certification: 1 Natural 2 Accident 5 Pending (Month, Day Year) investigation 1 ☐ Yes 2 ☐ No 24 hours after death e Funeral Director: filled in by the 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the l 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Watter, no BW 974 1871 November A, 2006 (nou 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar UNION Memorial

Hospital,

Watkins,

919

M.D.

32. Registrar's Signature

mes Matthew	Day					
		State of Maryland / Bopartino		ygiene		
		Redistrar	e of Death	Reg. N	0 200	c 2520
Physicia	_	Decedent's Name (First, Middle,Last)		2. Date of Death	200	3) Time of Death J U
edical Exami	ner	James Matthew Devorak		Month Day November 2, 2	7 Year 2006	1224 hrs
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
		Peninsula Regional Medical Center	Salisbury		Wicomico	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd	ay) If Under 1 Year If Under 24Hrs	8. Date of Birth (MI	M/DD/YYYY) 9. Birt	hplace (State or
Director		471-04-3548 1 XM 2 F 24	Yrs. Months Days Hours Min	. Oat 22	Foreig	
	ŀ	471-04-3548 1 XM 2 F 24 Usual Residence of Decedent	115.	Oct. 22,	, 1962	untry) MIN
any	1	10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
ž ,		MN Missoula Misso	1 -			1 Yes 2 X No
daryland 28a-f show 1 at once.	후	MN Missoula Missoula Missoula	10f. Zip Code	1100.0	itizen of What Cour	
or 28	Director			1.09.0	MIZOTO VITAL OOG	
215-0036 be flied within 72 hours after death with the Maryland nital Hygiene. rked other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at once.		Box 17404	59808		nited Sta	
th wi	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto		14. Race - Amen White, etc.	can Indian, Black,
r dea or it	ᇍ	1 Yes 2 X No				
5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner	ģ	3 Widowed 4 Moivorced If Yes, Give Year or Dates:	1 Yes 2 X No specify:		Specify: Wh:	
hour natu	þ	du du	cedent's Usual Occupation (Give kind of ring most of working life. DO NOT use ret		. Kind of Business/I	ndustry
36 hin 72 e. than "	ole1	Elementary/Secondary (0-12) College (1-4 or 5+)	of and Dawtondon		D	
withi iene.	Completed		nef and Bartender		Restaura	nt
Hyg Hyg d oth		17. Father's Name (First, Middle, Last)		e (First, Middle, Maide	en Surname)	
MD 21215-0036 d 2 should be filed within 7 lth and Mental Hygiene. n 27 is marked other than numatic event, the Medical	Be	Steven Devorak		le Stamp		
Shoul along Maric e	리		Mailing Address (Street and Number or	Rural Route Number,	City or Town, State	, Zip Code)
MI alth a m 27			ox 17404, Missoula,		The section of the sec	T
imore, MD 21215-00 Pages 1 and 2 should be filed wit ment of Health and Mental Hygien tont: If item 27 is marked other or other traumatic event, the M		1 Burial 2 VCremation 3 Removal from State cremator	Disposition (Name of cemetery, y or other place)		c. Location - City or	rown, State
Page lent c		4 Donation ,5 Other Specify: West Aru	ndel Crematory 11/0	5/2006 O	denton, Mar	yland
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and N Important: If item 27 is n injury or other traumatic.		turi of uneral Service Licensee M01113	22. Name and Address of Facility	arman Fune	eral Servi	ice, P.A.
W FEET		STIN	7221 Grayburn Driv			
Physician		23a. Part I. Inter the disease, or complications that caused the death. Do not e				Approximate Interval
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a, Torso Injuries				Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):				
		Sequentially list conditions, b				
	힏	if any, leading to immediate Due to (or as a consequence of):				
	盲	cause. Enter Underlying Cause (Disease or injury that initiated				
isi ed 7	Examiner	events resulting in death) Last Due to (or as a consequence of):				
executed an and an and an arransi	ical	d				
		UNPENDED AMENDED				
Records, P.O. Box 68760, The law requires that the death certificate be cate has been signed by the attending physicipage 2 should be detached for use as the buri		IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery	
certi	iar	past 12 months? 1 Live birth 2	Fetal death 3 Ectopic pregn	ancy	Month I	Day Year
Box s death c the atten	Sic	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)			
that the d	든	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in Part I.	23e. Did tobacc	co use contribute to	the cause of death?
, P.O.	٥			1 Yes 2	✔ No 3 Prob	ably 4 Unknown
duires en sig	Completed by			24a. Was an	I 24h Were au	topsy findings available
of Vital Records, ng Physician: The law requir ther this certificate has been s meral director, page 2 should I	용			autopsy performed	prior to o	ompletion of cause of
Rec The la	E			1 V Yes 2		s 2 No
	Bec	25. Was case referred to medical	26.Place of Death (Check	only one)		
Vital F ysician: his certifi director,	8	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outp	oatient 3 DOA Other A Nursi	ng Home 5 Resi	dence 6 Other	
n of ling Ph		27. Manner of Death 28a, Date of Injury 28b, Tir	ne of Injury 28c. Injury at Work?	28d. Describe how i		
- = ~ = 1	흲	Natural 5 Pending Nov 2, 2006 1151 h	ırs 1 Yes 2 ✔ No	Passenger invo	ived in auto ac	cident
Division spital or Attendir ours after death teral Director: A	Certification:	2 Accident Investigation 28e. Place of Injury - At home, farm	n, street, factory, office building, etc.	28f. Location (Street	t and Number or Ru	ral Route Number, City
Div saft	텙	Suicide Could not be		or Town, State) 5483 Purnell Cros	sing Rd . Powville	e. MD
in G B in		29a. Certifier 4 Continue Physical To the best of my knowledge death	popured at the time, date and place and			
To the Hos within 24 h To the Fun completely	Medical	(Check only one) 2 Medical Examiner: On the best of my knowledge, death one)				
To t With	led p	and manner stated.				
	2	29b. Signature and title of certifier	29c. License number		d. Date signed (Mor	
, i		C can	O.C.M.E.	No	ovember 3, 200	96
10		30. Name and address of person who completed cause of death (Item 23a)				
1 I		Ling Li, MD Assistant Medical Examiner 111 Penn	Street, Baltimore, MD 21201			
St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	8 - 10 -			

		ľ	1 - State Registrer	State of Ma	-	epartment of Certificate of			giene2005	35387
	Dhusisi		1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	th Day Year	3. Time of Death
	Physici /Medic		Susan	DIEHI				Novemb		
	Examir	er	4a. Facility Name (If not institution, give				, or Location of Dea timore	th	4c. County of Dea	tn
	Funeral		Keswick Multicare 5. Social Security Number 6. Ser		(In yrs. last birth	day) If Under 1 Yea	ar If Under 24 Hrs	s. 8. Date of Birth	n 9 Bir	thplace (State or Foreign
	Director		219–16–5738	M 254F	91 Y	s. Months Day	s Hours Min	Feb. 1.	3,1915 Mar	yland
	D.		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	Aanyla	ō	Maryland N/A			timore				Yas 2☐No
	28a-	Director	10e. Street and Number			10f. Zip Code)		10g. Citizen of What C	ountry?
	3a or		3939 Roland	Avenue #92	21	212	11		USA	
36	2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. ie marked other than "natural", or Iteme 23s or 28s-f show aumatic event, the Medical Externing must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		13. Was Decedent o	uban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Whi Specify: Wh	te, etc.
ğ	2 hou	ted	15. Decedent's Edu	cation		ecedent's Usual Occ		net in e	16b. Kind of Business	/industry
215	thin 7	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+		Give kind of work dor ife. DO NOT use reti	red)	Jiking		
2	ygien ygien her th		11			Clerk	10 Mathada Na	ame (First, Middle,	Laundry	
Maryland 21215-0036	ntal Hed of	Be	17. Father's Name (First, Middle, Last) Henderson Shaw				Blan			
2	should nd Me mark	ဥ	19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. I	Mailing Address (Stre			r, City or Town, State,	Zip Code)
Ž	elth a 27 io		Patricia S. Konitz	zer Niece	14	0 Falling	Leaf Lan	e Elgin	s.c. 290)45
Baltimore,	of He of He fitem		20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ F	Removal from State	cemetery.	Disposition (Name of crematory or other p	place)	Date	20c. Location - City or	
Ĕ	Pag Iment tant: I		4 □ Donation 5 □ Other (Specify)		Lorrair	e Park Ce		/9/2006	Woodlawn,	Maryland
Ball	permit. Pages 1 and 2 should be Department of Heelih and Menia Important: if Item 27 ie marked eny Injury or other traumatic ev once.		21. Signature 11 uneral Service Licens	Den	1)	3631 Fal	enss-Seit ls Road.	Baltimore	l Home, Ind	1
	Physician /Medical Examiner		23a. Part1. Enjoythe disease, or compl shock, ortheart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a		v TEnsi	•	ac or respiratory an	rest,	Approximate Interval Between Onset and Death
8760,	cate be executed physicien and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of					
.O. Box 6	The law requires that the death certific ste has been signed by the ettending p page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death	3 ☐ Ectopic pregnar 5 ☐ Other (specify)			23d. Date of de Month	livery Day Year
ds, P	uires that n signed b ild be deta	þ	Part II. Other significant conditions co	1 .	-	he underlying cause FALLUR	_	23e. Did to	bacco use contribute t 'es 2 □ No 3 □ P	o the cause of death?
Ö	s been si	Completed	diabete		litus	Type	OWE	24a. Was	an 24b. Were a	utopsy findings available
<u>~</u>	hysician: The law his certificete has I I director, page 2 s	mo		Ins UFFI		1		autop perfor 1 Tes	med? death? 2. No 1 ☐ Ye	completion of cause of s 2 Ŝ₩o
/ita	cian: ertifica	Be	25. Was case referred to medical axaminer?		0.0			eath (Check only or	ne)	
5	Physic this co	ဥ	1 ☐ Yes 2 🟋 No		2 ER/Outp	atient 3 DOA		T.	lence 6 Other (Spe	ecify)
UQ.	ding f h. After funer	tion	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	Year) 28b. Tii	ury V	Vork? ☐ Yes 2 ☐ No	28d. Describe ii	low injury occurred	
Division of Vital Records,	i or Attending Physician: after death. Director: After this certific I in by the funeral director,	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	y - At home, farr (Specify)	n, street, factory, offic		28f. Location (S City or Tow	Street and Number or F m, State)	lural Route Number,
_	splta hours ineral y fillec	edicai Co			examination and				cause(s) and manner a date and place, and du	
	To the Ho within 24 To the Fu completel	₩	29b. Signature and title of certifier	` ^		29c. Lice	ense number	:	29d. Date signed (Mon	th, Day, Year)
)	0		I Guarry	on mo						
	19		30. Name and address of person who co					n the	14 7	101 k - 2 - 2
	1		HILAN DON T	N · D. 70	O WES	univer	5174 7	O in 3	itrect B	M. [(WION, T
90	Sta Regist		NOV A D 288E	4	K A					

			For State Registrar	State of Mai	ryland	/ Depa <i>Cen</i>	rtment of He tificate of D	ealth and Death		gierje 0 0 5 Reg. No.	35388
	Physici /Medic		Decedent's Name (First, Middle, Last	" Alexis	D	ahl			2. Date of De Month	Day Year	
	Examin		4a. Facility Name (If not institution, give Augsburg Luthera	n Home			4b. City, Town, or Baltim	ore		4c. County of De	re
	Funeral Director		5. Social Security Number 6. Se X	□M 2□F	(In yrs. Ias 86	Yrs.	Months Days	If Under 24 Hr Hours Mir	n. (Month, Da	th ly, Year) 9. 8 2, 1920 Ma	irthplace (State or Foreign Country)
	rland sow		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	ation			,	10d. Inside City Limits
	he Mar 28a-f sh otified	Director	Maryland Baltimo	re	Ba1t	imore	10f. Zip Code			10g. Citizen of What (1 Tes 2 No
	th with (23a or 2		10e. Street and Number 6825 Campfield	Road, Apt.	11 I	.T.	21207		Ur	-	es of America
920	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show dical Examinet must be notified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 Tyyes 2 No If Yes, Give Year or Dates:		lf	/as Decedent of His Yes, specify Cubar ☐ Yes 2 No	spanic Origin? (, Mexican, Pue Specify:	Specify Yes or No irto Rican, etc.)	14. Race - An Black, Wh Specify: W	
Maryland 21215-0036	_⊆ 2,34	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de <i>completed)</i> College (1-4or 5+)	(Give k life. O	ent's Usual Occupa ind of work done di O NOT use retired)	uring most of w		16b. Kind of Busines	
121			17. Father's Name (First, Middle, Last)	3	<u> </u>	Purcha	seing Mar			Black & De	ecker
lano	D to D	To Be	Alexis S. Dahl						ne Strom	,	
Mar)	7		19a. Informant's Name/Relationship (T	ype, Print) (Spou	(00					er, City or Town, State	Zip Code) Ore, MD. 21207
Baltimore, I	of Heall		20a. Method of Disposition 1 Burial 2 Cremation 3 1 4 Donation 5 Other (Specify,	Removal from State	20b. Plac	ce of Dispos netery, crem	ition (Name of atory or other place ark Cemet)	Date 1/11/06	20c. Location - City of Woodlawn,	or Town, State 21207
Baltil	permit. Page Department Important: it eny injury o		21. Signature of Funeral Service Licens))	22.	Name and Address	s of Facility L			Directors,In
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of the composition of the composition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a	conseque	nce of):	r the mode of dying	, such as cardi	ac or respiratory a	rrest,	Approximate Interval Between Onset and Death
Box 68760, ~	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	ın/Medicai Examiner	23b. was decedent pregnant	c	f pregnanc	ey .	Ectopic pregnancy			23d. Date of d	
o.	at the deat by the att tached for	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at ti 9☐ Unknown			Other (specify)			Month	Day Year
rds, P.	w requires that been signed should be det	þ	Part II. Other significant conditions co	,	not resulti	-	dionion	. (.			to the cause of death? Probably 4 Unknown
of Vital Records,		Completed							24a. Was autor perfo 1 ☐ Yes	osy prior to ormed? death'	autopsy findings available ocompletion of cause of
Vita	sician: certific rector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2∰No	Hospital: 1 ☐ Inpatient	205	R/Outpatient	3□ DOA Othe	-	eath (Check only o	one) dence 6 □Other (Sp	posific)
		ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	2	8b. Time of Injury	28c. Injury Work			how injury occurred	ocity)
Division	To the Mospital or Attanding Ph within 24 hours after death. To the Funaral Director: After it completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur- building, etc.	y - At hom (Specity)	e, farm, stre	et, factory, office		28f. Location (City or Tox	Street and Number or i wn, State)	Rural Route Number,
	To the Hospil within 24 hour To the Funars completely fills	edical	29a. Certifier (Check only one) 12 Certifying Phy 2 Medical Exam	ysicien: To the best of liner: On the basis of e and manner state	examinatio	edge, death in and/or inv	occurred at the time estigation, in my op	e, date and placi inion, death occ	curred at the time,	date and place, and d	Je to the cause(s)
1	To the within 2 To the complet	Σ	29b. Signature and title of certifier	-	~	>	29c. License	number 737573		29d. Date signed (Mo.	nth, Day, Year)
			30. Name and address of person who described MD	empleted cause of dea		3a) (Type, F				21136	,
	Sta Registi		31. Date filed (Month, Day, Year) NOV 0 9 2005	32. Registrar		re	U				

DHMH 17 Rev 1/2001

			1 = For Amend Item	State of Maryland / Dep. 23a per dr. G861, H.	artment of Health and / 09/06dhb rtificate of Death	Mental Hyg	giene 005	35389
			1. Decedent's Name (First, Middle, Last			2. Date of Dea	th	3. Time of Death
	Physici		Donald F.	Dunnock		November	Day 7006	2318 PM
	/Medic Examin		4a. Facility Name (If not institution, give		4b City, Town, or Location of Dea		4c. County of Death	-1
	LAGITIII	Ξ.	Northwest Hose	61	Kandallstown /	4D	Raltin	nove
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Hr Months Days Hours Mir		9. Birth	place (State or Foreign
	Director		219-28-7838	M 2□F 73 Yrs.	INOTICIS Days Frodis	DEC. 2	0,1932	14d
	p ,		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation			10d. Inside City Limits
	anyla ehov	7	111	17.				1 Yes 2 No
	8 - 1 - 1 - 1 - 1 - 1 - 1	Director	Md Baltin	nore Pikesvill			10g. Citizen of What Cou	ntn/?
	vith ti	Dir	10e. Street and Number		10f. Zip Code		USA	THTY!
	• 23	rai	10 Ideal Court	12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Specify Yes or No-	14. Race - Ameri	can Indian
	item item	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No	If Yes, specify Cuban, Mexican, Pue	nto Rican, etc.)	Black, White,	
36	l', or	by	3 □ Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify:	2016
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or iteme 23a or 28a-f ehow ha Madical Examiter must be multied at	ed	15. Decedent's Ed		dent's Usual Occupation		16b. Kind of Business/Ir	ndustry
15	n "n	Completed	(Specify only highest grad	College (1-4or 5+)	e kind of work done during most of w DO NOT use retired)	orking	Eastein S	Prainless
212	filed with Hygiene ther the	E	12 +h		in Operator		Steel	
	il Hygir other	Bec	17. Father's Name (First, Middle, Last)		18. Mother's Na	ame (First, Middle,	Maiden Sumame)	
<u>a</u>	ould be Mental arked o	To E	Danlel Dunn	ock	C; 11;2	2 Myes	· ŝ	
Maryland	de la la		19a. Informant's Name/Relationship (7	γρο, Print) 19b. Mail	ing Address (Street and Number or I	Rural Route Numbe	r, City or Town, State, Zi	o Code)
-	and 2 lealth a m 27 to		/reggy Dunnog		deal Court 1	i hesvill	e 14d 212	08
ore	of He of He fitem		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	20b. Place of Disp cemetery, cre	osition (Name of matory or other place)	2 /1/	20c. Location - City or T	
Ĕ	Pages nent of I int: If it		4 □ Donation 5 □ Other (Specify	M GA OUL	URIDGE Consten		CIKNIOSE,	
Baltimore ,	permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr onca.		21. Signature of Foneral Service Licen	2	2. Name and Address of Facility	hatma	w-Harris F	uneral Hom
8	88 = 8		Deren Hos		240 Reisterston			Md 21215
		2	23a. Part1. Enter the disease, or comp	lications that caused the death. Do not en	ter the mode of dying, such as cardi	ac or respiratory ar	rest,	Approximate Interval Between
	Pnysician		Im ediate Cause (Final	Condidation	sclerolic Cardiov	ascular i	Jisease	Onset and Death
	/Medical	_	resulting in death)	a Due to (or as a consequence of):	3 / ((123)			
П	Examiner		Sequentially list conditions	b				
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of).				
	ate be executed hysicien and the burial-transit	Examiner	that initiated events	с.				
0	e exe ien a urial-	Ä	resulting in death) Last	Due to (or as a consequence of):				
8760,	ate b hysic the bi	dicai		d		·		
9		Med	IF FEMALE:	ATTACK TO THE PART OF THE PART				
Box	ath ce	an/	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy		23d. Date of delive	ery Day Year
-	the al	Sici	1 Yes 2 No	4 Pregnant at time of death 5 9 Unknown	Other (specify)			,
P.0	d by etack	F.		ntributing to death but not resulting in the	underheine enune awen in Part I	23e Did to	bacco use contribute to	the cause of death?
	The law requires that the death certific site has been signed by the attending page 2 should be detached for use as:	Completed by Physician/Med	Part II. Other significant conditions of	numbuling to death but not resulting in the	underlying cause given in Fait i.		res 2 □ No 3 □ Pro	
oro	een s	ted				•	-	
Ö	law lesb	ρie				24a. Was autop	an 24b. Were aut sy prior to co	opsy findings available ompletion of cause of
Vital Records,		် ပ				perfor 1 ☐ Yes	med? death? 2. No 1 ☐ Yes	2□ No
ita ita	ysician: is certific director,	Be	25. Was case referred to medical examiner?			eath /Check only or	ne)	
4-	hysi his c	ပ္	1 ☐ Yes 2 ☐ №0	Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatie			lence 6 Other (Spec	fy)
٥٥	ng P Viter t	- u	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time Injury	Work?	28d. Describe h	ow injury occurred	
Sio	Attending Physician: r death. ector: After this certific by the funeral director.	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		M 1 Yes 2 No	601		
Division of	or At iter d irect	Certification:	4 Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specity)	treet, factory, office	City or Tow	itreet and Number or Rui m, State)	al Houte Number,
	To the Hospital or Attending Phys within 24 hours effer death. To the Funerel Director: After this occupietely filled in by the funeral direction.		201 0 1511 15 5 151	Market W. M. Control of the State of the Sta	and the state of t	and they be the	and the same of th	tur. F
	Hose 14 ho Fune Fune tely f	edicai	29a. Certifier 1	iner: On the basis of examination and/or i	nvestigation, in my opinion, death oc	curred at the time,	date and place, and due	to the cause(s)
	the thin 2 the mple	Med	29b. Signature and title of certifier	and manner stated.	29c. License number		29d. Date signed (Month	Dav. Year)
	T W D	_	AN	1000			• .	*
,	(0)		トンル		1,4407))	ovember Ul	2006
			30. Name and address of person who	completed cause of death (Item 23a) (Type	(Frint)	t 0- 1	Vovember 01 Randallston	MD 21122
		1	1/50110 304N /T	1 1-47100	3401 Ula Co	ure koad,	1(andalls700	17 CI177
		ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 9,15,16b-22 per fit 8861 11-14-06 vit Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** DOWLING G-GOFFREY 10 29 2005 2052 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death AAMC AnneArunde ANNAPOLIS If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 0ct 29, 1952 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Months 54 Director 220-60-6231 Australia Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No MD Anne Arundel Annapolis 10e, Street and Number 10f. Zip Code ns 23a or 2 must be n 10g. Citizen of What Country? 1976 Scott Crossing Way 21401 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 M No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. Examiner 1 ☐ Yes 2 K If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Maryland 21215-0036 'natural', or 1 ☐ Yes 2 X No Specify: ģ Specify: white 3 Widowed 4 Divorced the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) broadcaster Radio ortant: If item 27 is marked othe injury or other traumatic event, 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) 1111 Be and 2 should be a John E. Dowling May Edith Troughton ဥ 19a. Informant's Name/Relationship (Type, Print)

Raymond F. Dowling/Brother

Anne Arundel Med etr 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
544 Open Hill Rd. Madison, CT. 06443
2001 Medical Pkwy Annapolis, MD 21401 permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【ACremation 3 ☐ Removal from State Baltimore Crematory 11-08-06 Baltimore, Md. 4 ☐ Donation → Other (Quecify) in state 32 Name and Address of Each John M. Taylor, Funeral Home 147 Duke of Gloucester St. Annapolis, Md. 21401 21. Signature of Funeral Service Sicensee Ronard . Wade, Director 23a. Part. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Varioics hemorrhage Physician Due to (r as a consquence of): /Medical Examiner END STAGE EPATIC FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): ALCOHOLIC HEPATITIS Due to (or as a consequence of): Records, P.O. Box 68760, attending physician Physician/Medical CHRONIC ALCOHOLISM IF FEMALE: If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Renal Failure 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed Chronic lung disease 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 : autopsy performed? Yes 2 No this certificate or Vital 1∐ Yes 2□ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of Certification: 28c Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 5 Pending investigation (Month, Day Year) death. 2 Accident 1 ☐ Yes 2 ☐ No hin 24 hours after death the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number ٥ 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar LUCINDA

31. Date filed (Month, Day, Year)

NOV 0 9 2006

MUNDORF

32. Registrar's Signature

DHMH 17 Rev 1/2001

Carle.

SUITE 400

116 Defense Hwy Annapolis MD

Please Type or Print in Black Indelible Ink

Nicole M. Edmonds State of Maryland / Department of Health and Mental Hygiene 3539 Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day November 7, 2006 Medical Examiner 0101 hrs <u>Michelle</u> Nicole Edmonds 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** Shock Trauma Center N/AIf Under 1 Year If Under 24Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) B. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Foreign Hours Min Directo 214-55-9902 1 M Yrs 2X X 7/19/1989 Md Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X XYes 2 No 28a-f show Baltimore Md. n/a death with the Maryland Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country 2910 Windsor Avenue USA items 23a Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 XXNever Married 2 Married Armed Forces? White, etc. Yes 2**XX**No þ If Yes, Give Year 1 Yes 2XXNo specify: Specify: Black 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry pleted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit Pages I and 2 should be filed within 72 P Department of Health and Mental Hygiene Important: If item 27 is marked other than "I injury or other traumatic event, the Medical E Baltimore, MD 21215-0036 Student Balto. School Com 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Wayne Edmonds Wanda Edmonds 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wayne Edmonds 2910 Windsor Ave., Baltimore, Md. 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date 20c. Location - City or Town. State crematory or other place) 1 X X Burial 2 Cremation 3 Removal from State 11/11/2006 Baltimore, Md Woodlawn Cemetery Donation 5 22. Name and Address of Facility
Estep Brothers Funeral Service.,
1300 Eutaw Place. Baltimore Md.

the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Appro Signature of Fyne al Sei Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. /Medical Death a Stab wounds (2) of chest Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) ner cause. Enter Underlying Cause Exam (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). The law requires that the death certificate be executed and sician/Medical UNPENDED AMENDED Box 68760, 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy 2 Month Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown 돈 Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has performed? death? ✔ Yes 2 1 🗸 Yes No 26 Place of Death (Check only one) Fo the Hospital or Attending Physician: 25. Was case referred to medica Be examiner? Other₄ DOA Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 1 🗸 Yes 2Ba. Date of Injury (Month, Day Year) Nov 7, 2006 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Subject stabbed 0030 hrs 5 Pending 1 Yes 2 ✔ No by the 2 Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 6 Could not be Suicide or Town, State)

1 W. North Ave, Baltimore, MD determined (Specify) Sidewalk 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical within 2 To the 1 2 😿 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and hile of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E November 7, 2006 who completed cause of death (Item 23a) 30. Name and add ess of perso Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month 32. Régistrar's Signature State Day, Year) Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Day Edward R. Ehman, Jr. November 2006 5:01 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Timonium Baltimore 57 Belfast Road 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Months Days Hours 219-30-2208 71 Director 1935 Maryland 10, Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a, State 10c. City, Town or Location 10d. Inside City Limits Md. Baltimore Timonium Director 1 ☐ Yes 2X☐ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 57 Belfast Rd. 21093 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by White Specify: 3 ☐ Widowed 4 ☑ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) General Contractor Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward R. Ehman, Sr. Clara M. Snyder P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26 Perryoak Place Baltimore, Md. 21236 Laura Lusby/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Co. 11-8-06 4 □ Donation 5 □ Other (Specify) Towson, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Towson Funeral Home, York Rd. Towson, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Disease Physician disease or condition resulting in death) /Medical INSSLIN DEPENDENT Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) To the Hospital or Attending Physlclan: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of). Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnar 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ No 3 Probably 4 Unknown アッシュアリン Yes 2□ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1□ Yes 2□No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural Injury 5 Pending 2 ☐ Accident investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: completely filled in by the 3☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar

29b. Signature and title of certifier

30. Name and address of person who

14 ICMARIO

le

empleted cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

MAFFEZZUZ;

29c. License number

207132

515 FAIRMOUNT AVE TOWIN, Md 21286

11/6/2006

State of Maryland / Department of Health and Mental Hygiene Drew Phillip Eggleton 2006 35393 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day November 5, 2006 Drew Philip Eggleton 0937 hrs Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Potomac Montgomery 8167 Inverness Ridge 5. Social Security Number 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Months Days Hours Director 313-88-7434 11-12-1982 23 IN 1 X M 2 F Country) Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits Potomac 1 X Yes 2 No MD Montgomery permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho righty or other traumatic event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8167 Inverness Ridge Rd. 20854 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, 11. Marital Status Armed Forces? White etc. 1XX Never Married 2 Married 2XX No Yes Specify: White 1 Yes 2XX No specify: Widowed Divorced If Yes, Give Year þ Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 12 Server Restaurant 18 Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Florian Patrick Eggleton Victoria L. S. E. Wagner Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0190 VA 19a Informant's Name/Relationship (Type, Print) Victoria S. Wagner/mother 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a Method of Disposition crematory or other place) Burial 2 XXCremation 3 Removal from State Chesapeake Crematory 11/8/06 Beltsville, MD Other Specify. 22. Name and Address of Facility CAFA Signature of Funeral Service Licens 8717 Green Pastures Dr Baltimore MD Pan I Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval Between Onset and failure. List only one cause on each line /Medical Death a. Hanging Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical UNPENDED **AMENDED** Division of Vital Records, P.O. Box 68760, IF FFMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year Fetal death Day past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è Yes 2 V No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a, Was an autopsy prior to completion of cause of performed? death? ✓ Yes 2 2 No 1 Yes Fo the Hospital or Attending Physician: 25. Was case referred to medical 26 Place of Death (Check only one) Be Hospital: 1 Inpatient 2 V ER/Outpatient 3 Dther 4 DDA Nursing Home 5 Residence 6 Other 1 V Yes 28a. Date of Injury FOUND: Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Subject hanged self FOUND: Natural 1 Yes 2 V No Pending Nov 5, 2006 0930 hrs Accident Investigation 28e Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 8167 Inverness Ridge, Potomac, MD determined (Specify) Multi-Family Apt. Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and htle 29c License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 6, 2006 30. Name and address of person who domp ted cause of death (Item 23a) Assistant Medical Examiner Susan Hogan MD 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State 9 2006 Registrar DHMH 17 Rev 1/2001 ORIGINAL

Please Type or Print in Black Indelible Ink

OCMF 2006

06-08386

			1 - State Registrar	ate of Mary	/land / L	epartm <i>Certific</i>	nent of F cate of	Health and M <i>Death</i>	lental Hy	giene 2	006	35394
	Physici	an	Decedent's Name (First, Middle, Last)						2. Date of De Month	Day	Year	3. Time of Death
	/Media	cal	Franklin Edward Fish 4a. Facility Name (If not institution, give street			4h	City Town o	or Location of Death	Novemb		nty of Death	c7.26 PM
	Examir	ier	BALTIMORE HASHINGTO		KAL C	ENTE	40	en Burn	n e		,	Purui DE I
	Funeral Director		5. Social Security Number 6. Sex 15 M 2	7. Age (In	yrs. last birt	hday) If L	Inder 1 Year oths Days		8. Date of Bir (Month, Da OCT 24			place (State or Foreign intry)
0/	yland sow		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Towr	or Location	1					10d. Inside City Limits
2	a-feh	ctor	MD Anne Arunde	21	Glei	n Burr	nie					1 □ Yes 2 □ No
4	or 28	Dire	10e. Street and Number				f. Zip Code			10g. Citizen	of What Cou	ntry?
HS	eath v	erai	807 Castle Rd	as Decedent Ever	r in 11 S		21061	discoppie Ostain? (Soc	naifu Van ar Na	USA	lace - Ameri	ess tedies
= / 5	be filed within 72 hours after death with the Maryland nial Hygiene. bd other than "naturel", or Iteme 23a or 28a-f ehow event, the Medical Examinar must be notified at	by Funeral Director	1 Never Married 2 Married 1 If	med Forces? ☐ Yes 2 No Yes, Give ear or Dates:	1110.3.		es 2 No	dispanic Origin? (Spe an, Mexican, Puerto Specify:	Rican, etc.)		Black, White,	, etc.
f 5-0	72 ho natur	eted	15. Decedent's Education (Specify only highest grade com	pleted)	16a.	Decedent's	Usual Occup	pation during most of worki	na	16b. Kind of	Business/In	Idustry
N, F1	within ane. than "	Completed		ollege (1-4or 5+)	Por	ofer	OT use retired	during most of worki d)	,9	Cong	tructi	on
		ပိ	17. Father's Name (First, Middle, Last)		NOC	rer		18. Mother's Name	(First, Middle,			.011
JKLI	2 should be and Mental 1s marked o	To Be	Eugle Hart Fisher					Catheri	-			
Alany	S P E E		19a. Informant's Name/Relationship (Type, Pr	rint)	19b.	Mailing Add	dress (Street	and Number or Rura	l Route Numbe	er, City or Tow	m, State, Zij	code)
. 3	l and lealth im 27		Virginia Chrystal, Da 20a. Method of Disposition	uhter	2]	F Rega	alia C	t Owings N	Mills,			
FRANK Baltimore, Mar	permit. Peges 1 and 2 Depertment of Health a Important: If Item 27 is any Injury or other tra once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Remov 4 ☐ Donation 5 ☐ Other (Specify)	al from State	Ob. Place of cemetery (etro (crematory Cremat	or other plac	Inc. 11/9/		20c. Location Baltimo		
Bal Bal	permit. Pe Depertmen Important: any Injury		(T.D.)	. Todd I		Crem 299	Frede	Society o	Baltimo	re MD	[nc. 21228	
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau		4	ot enter the	mode of dyir	ng, such as cardiac o	r respiratory ai	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical	8 1	Immediate Cause (Final disease or condition resulting in death)	setemic	- CA	37/CiSit	ormo	PATHY				5.1001 Q.102 DOUIT.
50 E.N.	Examiner		1	Due to (or as a co								
	P =	ner	S. wentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a co	nsequence c	f):						
11/2.	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co			CATI	DH		·		
,60,	lificate be executed g physicien and as the burial-transit	aiE		ANEM	•	17.						
68760	ificate g phys as the	edicai	d									
.O. Box	Attending Physicien: The law requires that the death cert r death. ector: After this certificate hes been signed by the ettendin by the funeral director, page 2 should be detached for use	Physician/M	in the past 12 months?	yes, outcome of pr Live birth 2 Pregnant at time Unknown	Fetal death		nic pregnancy or (specify)	,			Date of delive Month	ery Day Year
rds, P	quires that n signed b uld be deta	Ď	Part II. Other significant conditions contributi	ng to death but no	ot resulting in	the underly	ing cause giv	ren in Part I.		obacco use co		he cause of death?
Division of Vital Records, P.O.	To the Mospital or Attending Physicien: The law requires the within 24 hours after death. To the Funeral Director: After this certificate hes been signed completely filled in by the funeral director, page 2 should be de	Completed									o. Were auto prior to condeath?	opsy findings available impletion of cause of
/ita	ertifica ector, j	Be	25. Was case referred to medical examiner?					26. Place of Death			10,703	
of \	Physi this c	၉	1 ☐ Yes 2 ☑ No Hospita	1 Minpatient	2 ER/Out		DOA Oth	4 Nursing Hon				y)
o L	ding h. After funer	tion	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	. Date of Injury (Month, Day Yea	ar) 28b. Ti	me or jury M	28c. Injur Wor	yat k? Yes 2 □ No	8d. Describe h	now injury occi	ırred	
Divisi	a or Attendi after death. I Director: A d in by the fu	Certification:	a Could not be	Place of Injury - building, etc. (S	At home, far pecify)				8f. Location (S City or Tow	Street and Num m, State)	nber or Rura	al Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 V Certifying Physician: (Check only one) 2 Medical Examiner: O ar	To the best of my n the basis of exa nd manner stated.	knowledge, mination and	death occur or investiga	rred at the tin ation, in my o	ne, date and place, a pinion, death occurre	nd due to the o	cause(s) and r date and place	nanner as st	lated. the cause(s)
	To th withir To th comp	ž	29b. Signature and title or certifier		_		29c. License			29d. Date sign	ied (Month,	Day, Year)
			15/00 Days	5	ne	>	749	5149	2	IOVEM	BER	7 2006
	4		30. Name and address of person who complete 30	1 Holes	ntal	DV.		Hen Bu	rnie	MS	ひして	o l
	Sta Registr		31. Date filed (Month, Daly-Year) NOV 0 9 200	32. Registrar's 3	Signature	a for	and I					

			State o	f Maryla		artment of <i>rtificate of</i>		Mental Hy	rgiene Reg. No.2006	35395		
	sician edical							2. Date of Death Month Day November 7, 2006 3. Time of Death 5:45 am				
	miner	As the comment of the				r Location of Deat	4c. County of Dea Balti					
Funer Direct					. last birthday) Yrs.	ff Under 1 Year Months Days		8. Date of Bir (Month Da		thplace (State or Foreign ountry I and		
/land		Usual Residence of Decedent 10a. State 10b. County	10c. City, 1			ocation			10d. Inside City Limits			
Ba-fsh	ctor	MD Baltim	Towso	П			1 □ Ye					
th with the 23a or 2 and be re	al Dire	10e. Street and Number 112 Burke Avenue				10f. Zip Code 21 28	6		10g. Citizen of What Co	ountry?		
Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentai Hygiene. Important: if item 27 is marked other than 'natural', or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinal must be notified at	by Funeral Director	3 ☐ Widowed 4 XDivorced	Armed Forces? Never Married 2 Married 1 Yes 2 No If Yes Give			Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 € No		(Specify Yes or No erto Rican, etc.)	ecify Yes or No- Rican, etc.) 14. Race - American Indian Black, White, etc. Specify: White			
15-0 72 ho natur	leted	15. Decedent's Ed (Specify only highest grad	15. Decedent's Education (Specify only highest grade completed)		16a. Dece	dent's Usual Occu kind of work done DO NOT use retire	pation during most of w	orking	16b. Kind of Business	/Industry		
212 d within giene.	Completed	Elementary/Secondary (0-12)	omentary/Secondary (0-12) College (1-4or 5+)		Teacher				Educati	ation		
and d be file antai Hy ed othe	Be C	17. Father's Name (First, Middle, Last)	_		18. Mother's Nar				ne (First, Middle, Maiden Surname) B Souris			
Mary nd 2 shoul lth and Me 27 Is mark traumati	2	19a. Informant's Name/Relationship (T	19a. Informant's Name/Relationship (Type, Print) Nicholas P. Georges-son			Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 507 Chadwick Rd., Timonium, MD 21093						
Baltimore, Maryland 21215-0020 semit. Pages I and 2 should be filed within 72 hours at Department of Health and Mental Hygiene. Exportant: if I leen 27 Is marked other than "natural", or any Injury or other traumatic event, the Medical Examination of the properties.		20a. Method of Disposition Mare of Disposition Disposition 2 Description 20b. Place of Disposition (Name of cemetery, crematory or other pink 4 Donation 5 Dother (Specify) 5 Description						Date 11/10/0	20c. Location - City or 6 Baltimor			
Balti pemit. Departmimporta	once.	21. Signature of Funeral Service Licenseeddilliam G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 21204										
*,		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that can be cause on e	aused the dea ach line.	th. Do not ent	er the mode of dyi	ng, such as cardid	ac or respiratory a	rrest,	Approximate Interval Between		
Physicia /Medica Examine	al	Immediate Cause (Final disease or condition resulting in death)	a			Onset and Death						
n &	ner		or as a consec	quence of):		0						
68/60, (4) fificate be executed physician and as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury	or as a consequence of):									
		resulting in death) Last Due to (or as a consequence of):										
BOX leath ce attendir d for use	ician/	d										
S, F.O. BOX of that the death certifued by the attending be detached for use a	by Physician/M	Part II. Other aignificant conditions col	unting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 ☐ Yea 2 ☐ No 3 ☐ Probably 4 ☐ Unknown					
Scord w require s been si	Completed b	24a. Was an a performer								autopsy ed? 24b. Were autopsy findings available prior to completion of cause of death?		
a table	Co	25. Was case referred to medical					00 81			I □ Yes 2□ No		
ysicia ysicia is certi directe	To Be									idence 6 □Other (Specify)		
nding Phyath. ath. r: After this	ation:	27. Magner of Death 1 ☑ Natura! 5 ☐ Pending 2 ☐ Accident investigation	28a. Date o (Monti	28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work								
DIVISION OI VITAI To the Hospital or Attending Physician: " within 24 hours after death. To the Funeral Diractor: After this certifica completely filled in by the funeral director, p	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At he building, etc. (Specification)			me, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number) City or Town, State)					ral Route Number,		
e Hospi 24 hou e Funer	edical	29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
To th To th comp	W	29b. Signature and title of certifier		29c. License number 29d. Date signed (Month, Day, Year) 8 29d. Date signed (Month, Day, Year)								
5		290. Signature and pite of certifier 130. Name and address of person who completed cause of death (Item 23a) (Type, Print) 130. Name and address of person who completed cause of death (Item 23a) (Type, Print) 130. Name and address of person who completed cause of death (Item 23a) (Type, Print) 130. Name and address of person who completed cause of death (Item 23a) (Type, Print) 130. Name and address of person who completed cause of death (Item 23a) (Type, Print) 130. Name and address of person who completed cause of death (Item 23a) (Type, Print) 130. Name and address of person who completed cause of death (Item 23a) (Type, Print) 130. Name and address of person who completed cause of death (Item 23a) (Type, Print)								204		
S Regis	State strar	31. Date filed (Month, Day, Year) NOV 0 9 20	06 32.00	gistrar's Signa	iture	artis						

DHMH 16 Rev 6/95

			For 1 State Registrar	State of	Marylar	-	artment o			ental Hyg	jiene	n c	35396	
8,		113	Decedent's Name (First, Middle	e, Last)				, 504		2. Date of Dea		00	3. Time of Death	
	Physici		Olga Grunwald							Month Novemb	Day	Year 2006	11:30 A ^M	
	/Medic Examin							n, or Location	of Death	110 V CIIID		ty of Death	11.50 A	
150			Genesis Elder	Care Sever	na Par	k	Severn	a Park			Ann	e Aru	nde1	
No.	Funeral		5. Social Security Number	6. Sex 7.		last birthday)	If Under 1 Ye	ar If Unde	r 24 Hrs.	8. Date of Birth (Month, Day		_	place (State or Foreign	
	Director		214-30-5138	1□M 2₹ F	81	Yrs.	Months Da	ys Hours	Min.	02-26-	1925	Ukra	ine	
	DC &		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	antina						tod Inside City Limite	
	eho eho	5											10d. Inside City Limits 1 ☐ Yes 2X No	
	he M	ecto	MD Anne 10e. Street and Number	Arundel	GI	en Bur								
	a or	by Funeral Director					10f. Zip Cod				0g. Citizen of		ntry r	
	se 23	eral	302 Wende Way	12. Was Deced	ent Ever in III	C 13	2106	.,	rigin? (Spe	ody Voe or No	U.S.,		can Indian	
	ter d	'n	1 Never Married 2 Marr	Armed Forc	1 ☐ Yes 2 🖾 No		Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica 1 ☐ Yes 2 No Specify:			Rican, etc.)	Bla	 Race - American Indian, Black, White, etc. 		
39	al', or	by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give							Speci	ity: whi	lte	
Ş	within 72 hours atter death with the Maryland ene. then "natural", or Iteme 23a or 28a-f ehow ha Medical Exartinal reaal be notified at	To Be Completed	15. Deceden		16a. Decedent's Usual Occupation (Give kind of work done during most of work					16b. Kind of Business/industry				
2	e. en en		(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)			life.	kina oi work ao DO NOT use re	st of workir	ng					
7	ad wi		n/a			Seam	stress				Facto	ory		
p	d oth		17. Father's Name (First, Middle,	Last)				18. Moth	ner's Name	(First, Middle,	Maiden Suma	me)		
<u></u>	Men Merke		unknown						unkne					
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 28a-f show eny figury or other traumatic event, If a Medical Examinational Ba notified all page.		19a. Informant's Name/Relations			19b. Mailir	ng Address (Str	eet and Numb	ber or Rura	Route Number	, City or Town	n, State, Zip	Code)	
d)	l and lealth im 27 her t		Mr. Jerome Grab	owski / ne		170	l Brickl	house		Fallst				
0	ges it of F		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 Removal from St	alo		sition (Name of matory or other				20c. Location	- City or To	own, State	
Ë	tmen tant:		4 Donation 5 Other (S		Hol	_	ry Ceme				Dunda1			
Bal	permi Depar Impo Impo eny Ir		21. Signature of Funeral Service	Licensee						ngleton				
	40104	-	Jan M.	fare	MOI					en Burn		21061		
ŧ			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death										Interval Between Onset and Death	
ja =	Physician /Medical	er	Immediate Cause (Final disease or condition resulting in death)	a. Pul	oul monary embolis hours									
*	Examiner			Due to (or	Due to (or as a consequence off:									
/ neto	\$ **		f any, leading to immediate cause. Enter Underlying	b. Due to (or	b									
	uted d ansit	E	cause. Enter Underlying Cause (Disease or injury that initiated events	S .										
oʻ	te be executed ysician and te burial-transit	Examiner	resulting in death) Last	Due to (or	Due to (or as a consequence of):									
8760,		icai		d.										
39	leath certifica attending phy I for use as th	Med	IF FEMALE:	1										
Вох	ath ce trendi	an/	23b. Was decedent pregnant in the past 12 months?		outcome of pregnancy ve birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy					23d. Date of				
o.	the a	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnar 9☐ Unknow		time of death 5 Other (specify)					Month Day Year			
<u>a.</u>	res that the death signed by the atter I be detached for u	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause given in Part I.								an cause of death?			
Records,	Physician: The law requires that the death certifica this certificate has been signed by the attending phy all director, page 2 should be detached for use as the	d by	and the second second second							_				
ö	w requir been si should	ete												
ğ	has pe 2	Completed								autops	utopsy prior to completion of cause of			
ā	ician: Th certificate rector, pag				1 ☐ Yes 2 2 No 1 ☐ Yes 2 ☐ No									
Vital	ysician: The is certificate hadrector, page	o Be	25. Was case referred to medical examiner?	Hospital:		500	-0-0-1	Other		Check only on				
Division of	Physic this stal di	-	1 Inpatient 2 EMOutpatient 3 UOA 4 Mursing Home 5 Residence 6 Other (Specify)								v)			
o	th. : After s funer	tior	1 Accident 5 Pendin	Work? M 1 ☐ Yes 2 ☐ No			,							
VIS.	or Attending after death. Director: After in by the fune	ifica	3 Suicide 6 Could i	ome, farm, str				28f. Location (Street and Number or Rural Route Number,						
	al or A s after al Direct	Certification;	4 Homiciae	building	, etc. (Specif	y)				City or Town	n, State)			
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	dical (29a. Certifier 1 ertifyin	g Physician: To the b	est of my kno	wledge, death	occurred at the	e time, date a	nd place, a	nd due to the ca	ause(s) and m	anner as st	ated.	
	To the H within 24 To the F complete	Φ.	one)	Examiner: On the bas and manne	r stated.								* *	
	To with	Σ	29b. Signature and title of certifi-	111	7		29c. Lice	ense number	7,	E. 2	9d. Date signe	ed (Month, i	Day, Year)	
•	π,	,				NIL) ,	000	10	2	11-3) - a	006	
	10		30. Name and address of person	who completed cause	of death (Item	23a) (Type,	Print)	1	1	. 11	11.	.11	MIN SILVE	
00	C.		31. Date filed (Month) Day Year)	redinge	istrar's Signa	ture	horasti I	1115 17	wy	10/1/	1815V	, lle	Day, Year) 1006 MD 21108	
9.	Sta Registr		NOV-0	9 2006	THE SALLS	15			U					

		•	For State Registrar	State of	Marylan		artment <i>tificate</i>			ind Me)6	3539	37
Ш	Physicia	an	Decedent's Name (First, Middle, Last) ADELE			GII	LDMAN	N		2	Date of Dea	BER 7, 2	2006 2006	3. Time of De 1:10 A	
	/Medic		4a. Facility Name (If not institution, give st	reet and num	ber)				Location of	f Death	11012112	4c. County			
			6208 WINNER AVENU				If I lade		BALTI			1	0.000	N/A	
	Funeral Director		5. Social Security Number 6. Sex 1 1	M 2 F	7. Age (In yrs 100	last birthday) Yrs.	If Under Months	Days	If Under 2 Hours	Min.	B. Date of Birth (Month, Day 11/20/1		Cou	place (State or F intry)	-oreign
	D		Usual Residence of Decedent			y, Town or Lo	cation					300		10d, Inside City	Limits
	Maryla f shov	ō	MD 10b. County N/A		100. 01		IMORE							1 Yes 2	
	or 28a	lrec	10e. Street and Number		1		10f. Zip	Code				10g. Citizen of \	What Cou	intry?	
	death with the Maryland ms 23a or 28a-f show	Funeral Directo	6208 WINNER AVENUE	2 Was Docor	dent Ever in U.	C 13		2121		nin? (Spec	ify Yes or No-	U.S.		ican Indian,	
	or Item		11. Marital Status 1 Never Married 2 Married	Armed Fore	ces? 2 (X) No		fYes, spec		Specify:	, Puerto Ri	ify Yes or No- ican, etc.)	Blac Specify	ck, White,		
2-003c	n 72 hours after death with the Marylan "natural", or Items 23a or 28a-f show colcal Examinar must he notified at	ed by	3 🎇 Widowed 4 □ Divorced 15. Decedent's Educ	Year or Da	tes:		dent's Usua				6	16b. Kind of B			
<u>.</u>	within 72 ene. than "nat	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-	4or 5+)	(Give	kind of wor DO NOT us	k done di	uring most	of working	7	TOD. KING OF D	2511195-2411	ladsity	
A	filed witl Hygiene ther the	Com	12			OWNE	:R	-	10 Matha	da Nama /	(First Middle	RE' Maiden Suman	TAIL		
yland	B la B	o Be	17. Father's Name (First, Middle, Last) MORITZ		SC	HOENEM	IANN			AROLI		Maluen Suman	18)	BADMAN	
Mary	s 1 and 2 should f Health and Mer ltem 27 ta marke other traumatic		19a. Informant's Name/Relationship (Type GARY SCHOENEMANN /		AJ							r, City or Town, MILLS,			
ย์	s 1 and I Health tem 27 other t		20a. Method of Disposition		20b. F	Place of Dispo	sition (Nam	ne of		Da	_	20c. Location			
E	e ° = 5		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from S	state	RA AHA	VAS C	HESE	D 1	1/08	/2006	RANDALI	STON	N, MD	
gail	permit. Pag Department Important: any Injury o		21. Signature of Funeral Service Lice 11.	7 -		22	2. Name an	d Address	s of Facility	y SOL	LEVINS	ON & BE	≀0S.,	, INC.	10
		*	23a. Part1. Enter the disease, or complic	ations that ca	used the deat	and the second second second							LE,	MD 2120 Approximate Interval Betwo	
	Physician	1	shock, or heart failure. List only on Immediate Cause (Final disease or condition	e cause on ea	Mal 19	wand	4	1	115	tan	halle	jo e		Onset and D	
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):	11	7.80		***************************************			/	,,,	
7	D ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):									
_	be executed ician and burial-transit	Examine	that initiated events c. resulting in death) Last	Due to (or as a conseq	uence of):							-4		
3/60	rate be executed thysician and the burial-transit	Icai	L _a												
õ	death certificate e attending phys d for use as the	Physician/Med	IF FEMALE:	Sc. If yes, outo	come of pregna	ancy						23d Da	te of deliv	verv	
. Box	death e atten ed for u	ician	in the past 12 months? 1 □ Yes 2 □ No	1□Live bi	nth 2 ☐ Feta ant at time of d	Ideath 3	Ectopic pr Other (sp						onth	Day Ye	ar
J Ö	hat the de d by the a letached		9 ☐ Unknown Part II. Other significant conditions con		2011-1	ulting in the u	nderlying c	ause give	n in Part I		23e. Did to	bacco use con	tribute to	the cause of dea	ath?
ďs,	law requires that as been signed b 2 should be deta	d by	Frealty	SAN	drom	٩					1 🗆 Y	es 2 No	3 ☐ Pro	obably 4 🗆 Un	known
ecords,	e law require has been sig je 2 should b	Completed	· Happothy	rold	ings	1			1		24a. Was a	SV	prior to co	topsy findings av ompletion of cau	allable use of
<u> </u>	Page 4		gasons	mle	sten	nl.	F30	eef	/			2/2 No	death?	2 🗆 No	
VItal	ysician: 's certifice director, p	To Be	25. Was case reference to medical examiner?	ospital:	npatient 2	ER/Outpatie	nt 3 DC	Othe		of Death	e 52 Resid	<i>ne)</i> lence 6 ⊟Oth	ner (Speci	ufv)	
_ _ _	ding Phys h. After this funeral di		27. Manner of Death 1 Ø Natural 5 □ Pending	28a. Date of	nt Injury h, Day Year)	28b. Time o		8c. Injury Work	.?		3d. Describe h	low injury occur	red		
DIVISION	Attending Physician: r death. ector: After this certific by the funeral director,	ertification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place	of Injury - At h	ome, farm, st	M reet, factory		′es 2 🗆 l				oer or Rur	ral Route Numbe	Θr,
2	tal or first after al Dire	Certi	4 Homicide		ng, etc. (Speci						City or Tow	m, State)			
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examin one)	ician: To the er: On the ba and mann	asis of examina	owledge, deat ation and/or in	h occurred vestigation	at the tim , in my op	e, date an inion, dea	d place, ar th occurre	nd due to the o d at the time, o	cause(s) and made,	anner as s	stated. to the cause(s)	
	To the within 2 To the complet	Med	29b. Signature and title of certifier	10		<u>-</u> .	290	. License	number		,	29d. Date signe	d (Month,	, Day, Year)	
		1	* Muk	- Da	ekn	mo		De)	18	87		11/7/2	16		
	(0		30. Name and address of person who co	mpleted caus	e of death (Iter	m 23a) (Туре,	Print)	U 4	04	-58	1	alfini	nl	2/2/	/
18		ate	31. Date filed (Month, Day, Year)	新	egistrar's Signa	ature	artis				6				
13	Regist	rar	NOV 0 9 200	0	Michigan A	A STATE OF THE PARTY OF THE PAR									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35398 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Day** Month Nov 7006 Herderson 2:55PM 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death In yrs. last birthday) TIMORE If Under 24 Hrs. Under 1 Year 9. Birthplace (State or Foreign Min 1 M 2 4 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whal Country? 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes. 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 0 19a. Informant's Name/Relationship (Type, Print) mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2
Cremation 3 ☐ Removal from State 6/2006 GreenMount 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Macility Joseph L. Rus 21. Signature of Funeral Service Licensee Enter the disease, or complications that caseed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one results on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

the Maryland

permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryla Department of Heelih and Mental Hyglene, important: if item 27 is marked other then "natural", or iteme 23a or 28s-1 ehoveny, liqury or other treumatic event, the Madical Examinar must be mutified at once.

Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

2

To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificete hes been signed by completely filled in by the funeral director, page 2 should be detac

Division of Vital Records, P.O. Box 68760,

Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq Due to (or as a conseq Due to (or as a conseq	uence of):	Archiomy	opn (Ciz	
nysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 1027No 9 ☐ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d	I death 3 Ectopic			23d. Date of delivery Month Day Year
Completed by PI	PadJI. Other significant conditions con	etributing to dealh but not resu	ulting in the underlying SCASE PRIMAN		23e. Did lobacco	24b. Were autopsy findings available prior to completion of cause of death?
Be	25. Was case referred to medical examiner?			26. Place of Dea	th (Check only one)	
၉	1 □ Yes 2 □ No H	ospital: 1 4 Impalient 2	ER/Outpatient 3	DOA Other: 4 Nursing H	lome 5 Residence	6 ☐Other (Specify)
atlon:	27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how in	jury occurred
Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, street, fact y)	ory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, tle)
Medical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medicat Examin	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death occurre tion and/or investigation	ed at the time, date and place on, in my opinion, death occu	, and due to the cause rred at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
Σ	29b. Signature and title of certifier	p/ 11	2	9c. License number	. 29d. E	Date signed (Month, Day, Year)

DO052950

Registrar DHMH 17 Rev.1/2001

State

30. Name and address

31. Date filed (Month, Day, Year)

O VON

9 2006

of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygien For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 9:50 p Nov 2, 2006 Oliver Horton /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore Timonium** Stella Maris 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** No. Carolina Months Days Hours 1 ★M 2 F Yrs Mar 25, 1946 169-38-6539 60 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County , or iteme 23a or 28a-f ehow other treumstic event, the Medical Exactiner must be notified at 1 Yes 2 No Dundalk Director Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21222 U.S.A 613 Peach Orchard Lane deeth Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Nes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Black Specify δ 3 Widowed 4 Divorced "natural", Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other then Trucking Company Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ies 1 and 2 shouid be fii of Health and Mental H fitem 27 Is marked ott Julia Gray Oliver Horton Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 613 Peach Orchard Lane Dundalk, Maryland 21222 Sarah Horton Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Depertment of H
Important: If ites
eny injury or ott 1 □ Burial 2 □ Cremation 3 □ Removal from State Catonsville, Maryland 11/04/06 4 □ Donation 5 □ Other (Specify) Metro Crematory, Inc. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the death. shock, or healt failure. List only one cause on each line. Approximate Interval Between Onset and Death bolhot enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition Physician BLADDER CANCER resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner use as the burial-transit The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the ettending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Dav 4☐Pregnant at time of death 5 Other (specify) director, page 2 should be deteched 9 Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2 No has certificete 1 Yes 2 □ No 1□ Yes or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPICE Certification: To 1 Inpatient 1 ☐ Yes 2 X No 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? filled in by the funeral 28d. Describe how injury occurred 27 Manner of Death 28b. Time of After Injury 5 Pending 1 X Natural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident efter death 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) State 9 2006 0 Registrar

9:50

2006

NOVEMBER

OLIVER HORTON

State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Year Month **Physician** November 5, 2006 12:25P Harlow /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7110 Pickering Court Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) 08-13-1951 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 ☐ M 2 🖾 F 230-78-8478 55 **Director** VA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 end 2 should be filed within 72 hours after death with the Marylan anent of Health and Mental Hygiene.
ansit if item 27 is marked other than "naturel", or items 23e or 28e-f show ury or other traumatic event, the Medical Examinational be notified as ury or other traumatic event, the Medical Examinational be notified as 1 Tyes 2X No Director MD Anne Arundel Glen Burnie 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 7110 Pickering Court 21061 U.S.A. by Funerai 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Home Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pete Michaelangelo Patsy Taylor 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Richard S. Harlow /husband 7110 Pickering Court; Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Vets. Cem. 11-13-2006 Crownsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral Home, PA M01479 1 Second Ave SW; Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 57 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner After this certificate has been signed by the ettending physicien and funeral director, page 2 should be deteched for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☑ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 22 No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Director: A 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 | Homicide pellil within 24 hours a
To the Funeral I
completely filled 29a. Certifier 11全 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) us sell a Dellea, h.o. 03 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene o o c

0 4 0		3	5	4	0	
-------	--	---	---	---	---	--

			Certificate	te of	Death		Reg. No.	05 3	5401
	Physici	an	1. Decedent's Name (First, Middle, Last) Ar(le e Hovt			2. Date of De	Day	Year 3.	Time of Death
	/Medi Examir		4a. Facility Name (If not institution, give street and number)		4b. City Town, or Loc		4c. Count	y of Death	7000
_			Huve Arundel Gen Hosp 5. Social Security Number Unk 6. Sex 7. Age (In yrs. last birthday) If Under		If Under 24 Hrs.	Poli's		7 A 9 Birthplace	(State or Foreign
	Funeral Director		1∑M 2□ F 67 Yrs. Months	Days	Hours Min.	8. Date of Bir (Month, Da Sept 7	iy, Year) • 1939	Country)	(State or Foreign unk
	a-f show	ctor	Usual Residence of Decedent 10a. State	1e					Inside City Limits 1 ☐ Yes 21 No
	h with the 23a or 28 1st be not	Funeral Director	10e. Street and Number 10f. Zip 503 virginia Street	Code 216	566		-	What Country?	
020	be filed within 72 hours after death with the Maryland ital Hygiene. d other then "natural", or items 23a or 28s-f show event. The Medical Exercines must be notified at	þ	11. Marital Status unk 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Yes 2 □ X No ff Yes, Give Year or Dates: 13. Was Decedent Ever in U,S. Armed Forces? 1 □ Yes 2 □ X No ff Yes, Give Year or Dates:	dent of F cify Cub	lispanic Origin? (Spec an, Mexican, Puerto P	cify Yes or No lican, etc.)	- 14. Ra Bla	ce - American Ir ick, White, etc. fy: White	
N-C1717	ould be filad within 72 hours Mental Hygiana. erkad other then "naturai', atic event, the Medical Exa	Be Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unk 16a. Decedent's Usua (Give kind of wor. life. DO NOT us	al Occup ork done se retired	oation during most of workin d)	unk g	16b. Kind of B	Business/Industr	y un
land	should ba filad nd Mental Hygii merkad other imatic event,	To Be C	17. Father's Name (First, Middle, Last)	unk	18. Mother's Name	(First, Middle,	Maiden Surnar	ne)	unk
a y	2 should and Men ia marka raumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address	-					(e)
ore, r	permit. Pages 1 and 2 should Departmant of Health and Men Important: If item 27 ia merka any injury or other traumatic once.		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State		Pkwy Annar	Date Date		+OI - City or Town, S	State
Dallillo	permit. Pag Departmant Important: i any injury c once.		4□Donation 5 MOther (Specify) in state 21. Signature of Funeral Service Licensee Ronald S. Wade, Director State A	nd Addre Anat	ss of Facility Omy Board	655 W.	Baltin	ore Str	eet
			23a. Part 1. Inter the disease, or 6. mplications that caused the death. Do not enter the mode shock, wheart failure. List only one cause on each line.				rrest,	App	proximate erval Between
	Physician /Medical Examiner	ner	Immediate Cause (Final disease or condition resulting in death) a. Arterioscherotto Due to (or as a consequence of):	C			yd0.	Ons	set and Death
,00/00	The law requires that the death cardificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Medicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):						
. DO	w raquires that tha daath car bean signed by the attandir should be datached for usa	Physician//	d	ause giv	ren in Part I.	23b. Did 1	obecco use co	ntribute to the	ceuse of death?
֡֝֝֝֝֝֡֝֝֝֝֡֝֝֝֡֝֝֡֝֝֡֝֝֡֝֝֡֝֡֝֡֝֝֡֝֝֡֝	that the ned by t datach	by Phy				10	Yes 2□ No	3 Probably	4 Unknown
בר בר בר	aw raquires ts bean sig 2 should bo	Completed b					an autopsy rmed?	available	utopsy findings e prior to tion of cause 1?
5	: Tha l cata he r. paga					101	es 2 No	1 □ Yes	s 2□ No
<u> </u>	/sician s certifi diractor	o Be	25. Was case referred to medical examiner? 12√Yes 2 □ No Hospital: 1 □ Inpatient 2√√ER/Outpatient 3 □ DO/	OA Oth	26. Place of Death i er: 4□ Nursing Hom	•		ner (Specify)	
5	nding Phy ath, :: After this a funeral o	ation: T		8c. Injur			now injury occur		
	To the Hospital or Attending Physician: Tha law within 24 hours aftar daath. To the Funeral Director: Atter this certificate has completely filled in by the funeral director, page 2	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, building, etc. (Specify)	y, office	28	of. Location (5 City or Tow		ber o <i>r Rural R</i> ou	ite Number,
	he Hospit in 24 hour he Funere pletely fills	edicai	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred a 2 Medical Exeminer: On the basis of examination and/or investigation, and manner stated.						
)	To t To t	Σ	29b. Signature and title of certifier Deputy 29c.	D o	e number 90054	ž i	29d. Date signe	30/C	Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William P. Jowes, mb (o	99	00054 Ame	rict	4 6	2103	5
	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 9 2006 32. Registrar's Signature	P					

DHMH 16 Rev 6/95

NOV 0 9 2006

			1 - For State Registrar	State o	f Marylar	nd / Depa <i>Cei</i>	artment of H rtificate of	Health a Death	and Me	ental Hyg	iene 0 0	6	35402
	DI.		1. Decedent's Name (First, Middle,	Last)						2. Date of Deat	h		3. Time of Death
	Physici /Medi		Robert B. Hel	m						October	Day	Year 2006	0536 AM
	Examir		4a. Facility Name (If not institution,	give street and nur	nber)		4b. City, Town, o	or Location o			4c. County o		
Н			Washington Co	unty Hosp	ital		Hagers	town			Wash	ingt	on
	Funeral		5. Social Security Number		7. Age (In yrs.	last birthday)	If Under 1 Year Months Days		24 Hrs.	B. Date of Birth (Month, Day,		9. Birtho	lace (State or Foreign
	Director		218-30-9580	1∭ M 2□ F	94	Yrs.	Months Days	nouis	MIII.	July 5,	1912	Coun Mary	
	pu 🗼		Usuaf Residence of Decedent 10a. State 10b. County		10-10								
	anyla shor	2	MD Washir	arton		ty, Town or Lo						1	0d. Inside City Limits
	Me M	ecto		igcon		Hagers							1 ☐ Yes 2½ No
	Nith t	Director	10e. Street and Number				10f. Zip Code			10	og. Citizen of Wi	hat Coun	try?
	# 23	Funerai	20139 Landis R					21740			USA		
	er de	, a	11. Marital Status	12. Was Dece Armed For	rces?	J.S. 13. \	Was Decedent of F f Yes, specify Cub	tispanic Orig an, Mexican	gin? (Spec , Puerto R	ify Yes or No- ican, etc.)	14. Race Black	 Americ White, e 	
36	within 72 hours efter death with the Maryland ene. then "natural", or Items 23e or 28e-f show he Medical Examinar musitie indiffied at	Ϋ́	1 ☐ Never Married 2 Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1 ∐Yes If Yes, Giv Year or Da	0		I∐Yes 2∏No	Specify:			Specify:	wh	ite
Ş	hou	Completed by	15. Decedent's		1105.	16a Decer	lent's Usual Occup	nation		unk	Ch Kind of Dun	:	unk
15	in 72	ojet	(Specify only highest	grade completed)		(Give	kind of work done OO NOT use retire	during most	of working		6b. Kind of Bus	iness/inc	lustry
77	A the state of the	E	Efementary/Secondary (0-12) unk	College (1 unk	-4or 5+)			-/					
g	Hygothe office	Be C	17. Father's Name (First, Middle, L				unk	18. Mother	r's Name (First, Middle, M	faiden Sumame)	unk
au	ld be lental ked lc ev	To B											
Maryland 21215-0036	Shound N	-	19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailin	g Address (Street	and Numbe	r or Rural	Route Number.	City or Town. S.	tate. Zio	Code)
Ž	alth a		Washington Count	y Hospita	a1) Antieta					217	
Baltimore,	f Her f Her ltem othe		20a. Method of Disposition			Place of Dispo	sition (Name of	T	Da		Oc. Location - C		
Ë	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural; or Items 23s or 28s-f show any figury or other traumatic event, the Medical Examination mat be notified at ances.	1	1 ☐ Burial 2 ☐ Cremation 3 4 ☑ Donation 5 ☐ Other (Spe		State	<i>ж</i> тен т у, степ	natory or other plac	Ce)					
	Pariti. I		21. Signature of Fundral Service Linal d			. 22	. Name and Addre	ss of Facility	, ,	(55.00			
ñ	Der Per Per Per Per Per Per Per Per Per P	. 1	maid s	Wade, 1	recto		Name and Addre	omy B	oard	655 W.	Baltimo	re S	treet
			23a. Parl 1. Enter the disease, or c shock, or heart failure. List o	omplications that ca	used the deat	h. Do not ente	1timore, or the mode of dyin	ng, such as o	Cardiac or	respiratory arre	st.		Approximate
	Physician	i	Immedia e Cause (Final disease or condition			- 1	^						Interval Between Onset and Death
	/Medical		disease dr condition resulting in death)	a. Sire	20000	(a)	In fumer	1146	5-2	psis	Due		
	Examiner) O) 60C	or as a conseq		peumo	-		•			
		e.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (c	or as a conseq	uence of):	11201000	VI ~				_	
	d d ansit	Examine	Cause (Disease or injury that initiated events	1									
ó	exec an an rial-tr	Exa	resulting in death) Last	Due to (d	or as a conseq	uence of):							
8760,	icate be executed physicien and the burial-transit	dicai	4	d									
D	uffica ng ph as th	ed											
ROX	death certifi e attending I d for use as	Physician/Me	fF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo	ome of pregnanth 2 Feta						23d. Date	of defiver	ry
	deat e atte	Cla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregna	ant at time of d		Ectopic pregnancy Other (specify)				Month	n 1	Day Year
J.	at the de by the a tached	h y	9 Unknown	9∐ Unkno									
_	law requires that es been signed b 2 should be deta	by F	Part If. Other significant condition		ath but not res	ulting in the un	derlying cause giv	en in Part I.		23e. Did toba	cco use contrib	ute to the	e cause of death?
Vital Records,	w requir been si should I	ed	skin can	ev						1 ☐ Yes	2 1 No 3	☐ Proba	ably 4 ∐Unknown
ပ္ထ	awre as be 2 sho	Completed								24a. Was an	24b. We	re autop	sy findings available
ř	The The page or age	E							_	autopsy	ed? prid	or to com ath?	pfetion of cause of
Ia	sician: The law certificete hes t irector, page 2 s	O	25. Was case referred to medical					26. Pface	of Death (1 ☐ Yes 2 €		Yes 2	2 NO
	2 5	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	patient 2	ER/Outpatient	3□ DOA Oth			-	ce 6 □Other	(Specify)	
סר	ding Ph h. After th funeral		27. Manner of Death	28a. Date o	f Injury	28b. Time of	28c. fnjun Worl	y at			v injury occurred		
<u>ō</u>	ttendin death. tor: Af the fur	atio	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investiga		, Day (Gal)	Infury		k? Yes 2 ∐ N	lo				
UIVISION		Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 286. Place	of Injury - At ho g, etc. (Specif	ome, farm, stre	et, factory, office		281	Location (Stre	et and Number	or Rural	Route Number,
5	rs aft at Di ed in	Ce		Ballouri	g, did. (Specin	"				City or Town,	State)		
	To the Hospital or At within 24 hours affer of To the Funeral Direct completely filled in by	ledicai	29a. Certifier 1 Certifying (Check only 2 Madical Ex	Physician: To the I	pest of my kno	wledge, death	occurred at the tin	ne, date and	place, and	d due to the cau	ise(s) and mann	er as sta	ted.
	the trin 24 the F	ed		and mann	or stated.		estigation, in my of	pirilori, deatr	occurred	at the time, dat	e and place, and	d due to t	the cause(s)
	Son Veitl	Σ	29b. Signature and title of certifier	1	TPhist	-	29c. License				d. Date signed (
			muna c	Deceret.	D		HOO	611	7	0	CTUBER	20	1 2000
			30. Name and address of person w	~ /	- C	23a) (Type, F	Print) 251	E. V	In Time	oran	5)		2000
			Francisco A	1)aural			Mag	27278	w,	MO 3	1740		
	Sta	_	31. Date filed (Month, Day, Year)	32. Re	gistrar's Signa	ture	N. B		,				
	Registra	ar	NOV 0 9 20	UD CO	Stand Brass	of the same							

AMEND ITEM#5,11,15,16a&b,17,20a-c&22,perFH,G861,11/15/06,WS Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. #12& State of Maryland / Department of Health and Mental Hydica Co. Co.

			1 - State Amend #198 Registrar 1. Decedent's Name (First, Middle,	a&b Per Ana	Btf G861	Cei	715706 J tificate of	Death	2. Date of D	-	12 U U (3. Time of Death
	Physic		William Harri	S					Month Octob	er :	Day Yea 26, 2006	ar .
)	/Medi Exami		4a. Facility Name (If not institution,	give street and number)			4b. City, Town, o	r Location of Death			4c. County of De	
			2702 Keyworth	Avenue #305			Ba1	timore				
	Funeral Director		5. Social Security Numberunk (216-36-4118	5. Sex 7. Age 1 M 2 □ F	(In yrs. last b	irthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of B (Month, D Dec 5,	irth ay, Yea	9. 6	Birthplace (State or Foreigr Country) unk
	and wo		Usual Residence of Decedent 10a. State 10b. County]	10c. City, Tov	vn or Lo	cation					10d. Inside City Limits
	ath with the Marylan 23a or 28a-f ehow	ğ	MD	i	Balt	imor	·e					1√2 Yes 2 No
	r 28s	Director	10e. Street and Number				10f. Zip Code			10g. (Citizen of What	Country?
	th wit	a D	2702 Keyworth A	venue #305			2	1215			USA	,
36	within 72 hours after death with the Maryland ane then "neturel", or Itema 23a or 28a-f ehow 'sa Medical Examirer med Lea multified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 120 es 2 M N	ver in U.S.		Vas Decedent of H f Yes, specify Cuba		pecify Yes or N Rican, etc.)	0-		
21215-0036	ture Pture	edit	15. Decedent's	Year or Dates:	16a	Decer	lent's Usual Occur	ation	-unk	105		
215	nin 72	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed)	, 100	(Give	lent's Usual Occup kind of work done o OO NOT use retired	during most of wor. ()	king	160.	Kind of Busines	ss/Industry — Uni
21		ĕ	unk 11th	College (1-4or 5- unk	-)		Disab1				Disab	led
2	be filed tal Hygi d other	Be	17. Father's Name (First, Middle, La	ist)			unk	18. Mother's Nam	ө (First, Middle	, Maid	эл Sumame)	unl
<u>ya</u>		2	William Harris									
, Maryland	12 g h ar 7 le		19a. Aformant's Name/Relationship Sharon Jobes/C Baltimore City		198		o Marrord District	rkvatr Ba	tat Parion Pres	MD?	2121.Grate	o, Zip Code)
Baltimore,	Pages 1 end ment of Healt ant: If item 2 ury or other		20a. Method of Disposition 1 ☐ Burial 2 ▼Cremation 3 4 ☐ Donation 5 ∰ Other (Spe	cify) <u>in stato</u>	Green	ry, cren nount	sition (Name of natory or other plac : Crenatory	11-	Date -15–06	Bal	Location - City o	or Town, State
Balt	permit. Pag Department Important: I eny Injury o		21. Signature Leuneral Service Lin	Wade Dire	eror	100	Name and Address	Mark				Street
	Physician /Medical Examiner		Immediate Quese (Final disease or condition resulting in death)		J.	not ente	TETO LE	g, such as cardiac	or respiratory a	irrest,		Approximate Interval Between Conset and Death
	ecuted and transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	c. Un (on	consequence	of):	DIABET	rs Me	linus			20 yrs 20 yrs 20 yrs
68760,	lificate be executed g physician and as the burial-transit	edicai E	and an additional and a second		CONSEQUENCE CKASI				<u>-</u>			204.5
P.O. Box 6	The law requires that the death certificate be execu site has been signed by the attending physician and page 2 should be detached for use as the burial-trad	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1□Live birth 2 4□Pregnant at ti 9□Unknown	Fetal death		Ectopic pregnancy Other (specify)				23d. Date of d Month	elivery Day Year
	quires tha n signed I uld be det	<u>م</u>	Part II. Other significant conditions	contributing to death but	not resulting i	n the un	derlying cause give	n in Part I.	23e. Did t			to the cause of death?
Records,	The law requir ste has been si page 2 should l	Completed							24a. Was autoj perfo	osy ormed?	prior to death?	
of Vital	ysician: The ils certificete hi director, page		25. Was case referred to medical examiner?					26. Place of Deat	1 ☐ Yes	2 N	o 1 ☐ Ye	s 2 No
Ž	hysic his ce I dire	2	1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 ER/OL	itpatient	3□ DDA Othe				6 □Other (Sp	ecify)
Division o	To the Hospital or Attending Physician: within 42 hours after death . To the Funeral Director. After this certifice completely filled in by the funeral director, p.	Certification;	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not	ha -		Time of njury			28d. Describe			
Divi	ital or Al		4 Homicide determine	building, etc.	(Specify)				City or To	wn, Stai	te)	Rural Route Number,
	the Hosp in 24 hou the Fune ipletely file	edic	one)	Physician: To the best of aminer: On the basis of e and manner state	xamination an	o, death d/or inve	occurred at the time estigation, in my op	e, date and place, inion, death occur	and due to the red at the time,	cause(s date ar	s) and manner and place, and du	is stated. le to the cause(s)
	To To To To To To To To To To To To To T	2	29b. Signature and title of certifier				29c. License			29d. D	ate signed (Mor	nth, Day, Year)
)oum x	· WUL	M		05	1116		10	-31-6	06
			30. Name and address of person who	M /m	WE	14/	rint)					
	Sta Registr		31. Date filed <i>(Month, Day, Year)</i> NOV 0 8 200	i tegistiai	s Signature*	SON	E .					

DHMH 17 Rev 1/2001

			Pleas 1 - State Registrar	Se Type or Pri State of M	laryland / D)ера		Health and M	lental Hyg			35404
	Physic /Medi		Decedent's Name (First, Middle Richard M. Jon	,					2. Date of Dea Month Nov.		Year 06	3. Time of Death 1:10 A ^M
	Examir		4a. Facility Name (If not institution,)			or Location of Death		4c. County	of Death	
	Funeral		Stella Maris 5. Social Security Number	6. Sex 7. Ac	ge (In yrs. last birti	hdav)	I Imc	If Under 24 Hrs.	8. Date of Birth	Balt		elace (State or Foreign
	Director		216-48-2544 Usual Residence of Decedent	1 X M 2□F		Yrs.	Months Days		8. Date of Birth (Month, Day 9/16/	42 42	Cou	yland
	Marylan f ehow	tor	10a. State 10b. County		10c. City, Town						1	0d. Inside City Limits 1 ☐ Yes 2 ÂNo
	r 28a	irec	MD Balti 10e. Street and Number	more	Balt	1m o	10f. Zip Code			10g. Citizen of W	/hat Cour	
	23a o	aiD	5721 Oakland Rd	•			21	1229		USA		
1:10 a.m. 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23s or 28s-f show eny injury or other traumatic event, the Medical Examination in notilied at once.	Completed by Funeral Director	11. Marital Status 1 A Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces d 1 Yes 2 1 If Yes, Give Year or Dates:	? No		Vas Decedent of I Yes, specify Cub	Hispanic Origin? (Spe an, Mexican, Puerto Specify:	ocify Yes or No- Rican, etc.)	14. Race Black Specify.	k, White,	can Indian, etc.
2.0-S	72 ho	eted	15. Decedent's (Specify only highest	Education grade completed)	16a.	Decede	ent's Usual Occup	pation	20	16b. Kind of Bu		
1:10 1215-0	within ne. than	mpi	Elementary/Secondary (0-12)	College (1-4or	3+)			during most of worki	ng			
6 d 2	Hygie Hygie Sther	ပိ	12. Father's Name (First, Middle, L	ast)	EL	ect	rical E	Ingineer 18. Mother's Name	(First Middle	West:		ouse
2006 yland	fental	To Be	Martin L. Jo	nes				Mary C.			2)	
2, 2006 Maryland	and N		19a. Informant's Name/Relationsh	p (Type, Print)	19b.	Mailing	Address (Street	and Number or Rura			State, Zip	Code)
_	and sealth m 27		Cyndi Humphrey	/ Cousin			ndsbury			e, Mary	land	21060
NOVEMBER Baltimore,	iges 1 nt of H : If Ite or ot		20a. Method of Disposition 1 Description 2 Cremation :	3 □Removal from State	20b. Place of cemetery	Dispos , crem	ition (Name of atory or other pla	сө)	ate	20c. Location - (City or To	wn, State
H H	nit. Pa artmer ortant injury t.	1	4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service ☐	ecify)		Par	k Cemete	ery 11/6/	06	Baltimo	re, l	Maryland
Ba	Department of the position of		21. Signature of Furieral Service D	Consider the second				ess of Facility Lou				
			23a. Part1. Enter the disease, or cashock, or heart failure. List of	emplications that caused	d the death. Do no	ot ente	r the mode of dyir	ens Ave. B	r respiratory arre	e, mary.	Lana	Approximate
	Physician /Medical Examiner	ner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to conditions.	a. COLON C		f):						Interval Between Onset and Death
19°0928	be princip	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	a consequence of	f):						
P.O. Box 68	If the death certificate by the attending physicached for use as the inched	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death		Ectopic pregnancy Other <i>(specify)</i>	/		23d. Date Mon		ry Day Year
rds, P.C	w requires that the de been signed by the a should be detached f	ρ	Part II. Other significant condition	s contributing to death b	ut not resulting in t	the unc	derlying cause grv	en in Part I.				e cause of death?
Division of Vital Records,	The la te has bage 2	Completed	25. Was case referred to medical						24a Was ar autops perform 1 Yes 2	n 24b. W y pr ned? de	ere autop or to com ath? Yes	esy findings available apletion of cause of
' ₹	ysicia s cert directo	To Be	examiner?	Hospital:	ent 2 ER/Outp	nationt	3□ DOA Oth	er:				HOGDIGE
sion of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, s		27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investiga	28a. Date of Injui (Month, Day	ry 28b. Tir		28c. Injun	4 Nursing Horr		mce 6 <u>X</u>]Other w injury occurre		HOSPICE
Divis	ital or Att urs after de ral Directu led in by ti	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	building, etc			ŕ		City or Town	,		
	the Hosp nin 24 hou the Fune npletely fil	Medical		Physician: To the best of aminer: On the basis of and manner sta	of my knowledge, of examination and/ ated.	death of	occurred at the tin stigation, in my o	ne, date and place, a pinion, death occurre	nd due to the ca d at the time, da	use(s) and manute and place, an	ner as sta d due to	ited. the cause(s)
	To To	=	29b. Signature and fittle of certifier),			29c. License	e number	29	d. Date signed	, ,	
			20 Normand					45725		11/2	106	,
	8		30. Name and address of person when DR. TARIO MAHMO					UT1/01/27				
	Stat	e	31. Date filed (Month, Day, Year)	22 Pagietre	JLANEY VA ar's Signature			CIMONIUM,	MD 2109	3		
*	Registra	ar	NOV 0 9	2006	se As		MES					

DHMH 17 Rev 1/2001

NOVEMBER 2, 2006 1:10 a.m.

RICHARD JONES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death ent's Name (First, Middle, Last) 2. Date of Death VOV **Physician** 2006 /Medical 4a. Facility Name (If not institution, give street and number) County of Death **Examiner** DWM If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day vrs. last birthday **Funeral** 1 □ M 2 🖫 -008 Yrs. 220 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside Çity Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatte event, the Medical Examiner must be notified at 1 ☐Yes 2 ☐ No Director 10W 10e. Street and Numb Citizen of What Country? 10f. Zip Code Funeral Was Decedent Ever in U.S Armed Forces? Race 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by 3 ₩Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) er's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Name/Relationship (Type-Print) nformant's 00 own 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c Location - City or Town, 20a. Method of Disposition 1 Surial 2 □ Cremation 3 ☐ Removal from 4 □ Donation 5 Other (Specify) 21. Signature of uneral Service Lice DADWAY 14 21213 23a. Part1. Enter the disease, or complications that of led the death. Do not enter the mode of dying, such as cardiac or residence in a ry arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) disease erebrovasc **Physician** 10 ypans /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4 Pregnant at time of death ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 3 ☐ Probably 1 Tes 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has Yes 24 funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 5 Residence 6 ☐Other (Specify) Certification: To After this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 🗌 No within 24 hours after death.

To the Funeral Director: / 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 💇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20488

State Registrar

 C_{j}

31. Date filed (Month, Day,

9 2006 NOA 0

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Center L. Coles Ster W. 300 S. Church St. 32. Registrar's Signature

Middletown, MD 21769

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien) 35406 Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 1:20 PM Rose Gertrude Johnson Nov. 2006

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.

Days

21771

10f. Zip Code

Airy

Hours

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

4c. County of Death

10g. Citizen of What Country?

Specify

United States

Own Home

Olney, MD

23d. Date of delivery

29d. Date signed (Month, Day, Year)

NORMORY

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

812000

Month

14. Race - American Indian, Black, White, etc.

8. Date of Birth (Month, Day, Year)

Aug.

Frederick

DC

Birthplace (State or Foreign Country)

White

Approximate Interval Between

Onset and Death

reeyers

Year

10d Inside City Limits

1 ☐ Yes 2 No

Physician /Medical **Examiner**

Directo

Funeral

1 - State Registra

10a. State

5. Social Security Number

10e Street and Number

11. Marital Status

577-34-3527

Usual Residence of Decedent

4a. Facility Name (If not institution, give street and number)

6. Sex

Frederick

1 ☐ M 2 🖾 F

12. Was Decedent Ever in U.S. Armed Forces?

Kline Hospice House

10b. County

12803 Roughton Drive

Director death with the Maryland *Phow event, the Medical Examinar must be notified at filed within 72 hours after Hygiene. . Pages 1 end 2 should be file timent of Health and Mental Hy tant: if Item 27 is marked oth rilury or other traumatic even

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Department of important: if eny injury or

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this contact. physicien and s the burial-transit as the esn ō signed by the a page 2 s funeral director, hours after death. uneral Director: Aft sly filled in by the fur within 24 hours after de To the Funeral Directo completely filled in by th

Division of Vital

Funeral 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married Married 1 Yes 2000 Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Phillip Earnest Rose 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Calvin A. Johnson Husband 12803 Roughton Drive Mt. Airy, MD 20b. Place of Disposition (Name of cemetery, crematory or other place)
Norbeck Mem. Park Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Nov. 11, 2006 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensel 22. Name and Address of Facility Burrier-Queen Funeral Home & Crematory, 1212 W. Old Liberty Road Winfield, MD daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Part Enter the disease, or complications that k, or heart failure. List only one cause on mediate Cause (Final Sepsis ulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury Completed by Physician/Medical Examiner Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) ☐ Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2. No 3 Probably 4 Unknown 1 ☐ Yes autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a. Certifier (Check only one)

and manner stated

Stoner AR

32. Begistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

295

7. Age (In yrs. last birthday)

Yrs

10c. City, Town or Location

Mt. Airv

DHMH 17 Rev 1/2001

D

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

· Anelmo

29c. License number

301

100059943

vesminster/

	•		1 = State Registrar	State of	of Marylan	d / Depa <i>Cei</i>	artment o <i>tificate</i>	of Health ar of Death	nd Ment	al Hygie	ene 0	06	35407
			Decedent's Name (First, Middle, Las.	")						ate of Death	Day	Year	3. Time of Death
	Physicia /Medic		Addie Jenkins							tober			3:14 AM M
7	Examin		4a. Facility Name (If not institution, give	street and no	um <i>ber)</i>		4b. City, To	wn, or Location of	Death		4c. Coun	ty of Death	
			1111 N. Carrollto	on Aver	nue			Baltimore					
	Funeral		Social Security Number 6. Security Number	х]м 25ДF	7. Age (In yrs.		ff Under 1 \ Months D		Min. 8. Da	ate of Birth fonth, Day, V 7, 1	(ear)	Cou	place (State or Foreign
	Director		223-28-29/1	JW 5X1	82	Yrs.			Nov	v /, 1	923	Nort	h"Carolina
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. fnside City Limits
	laryli eho	ō	MD			Baltin	nore						1√2 Yes 2 □ No
	the A	Director	10e. Street and Number			Darer	10f. Zip Co	ode		100	g. Citizen o	f What Cou	ntry?
	vith of a		1111 N. Carrollt	on Arro	n110			21217				USA	
	99th	era	11. Marital Status		cedent Ever in U	.S. 13.	Was Deceden	t of Hispanic Origin Cuban, Mexican, I	in? (Specify Y	es or No-		ace - Ameri	
^	r iter	Funeral	1 Never Married 2 Married	Armed F	2 🔀 No				Puerto Rican	, etc.)		ack, White	
3	urs a	þ	3 Widowed 4 □ Divorced	if Yes, G Year or I	live Dates:		1□Yes 2☒	No Specify:			Spec	ity: b1	аск
Ş	72 ho	ted	15. Decedent's Ed (Specify only highest grad		1)		dent's Usuaf C	Occupation done during most of	of working	10	3b. Kind of	Business/Ir	ndustry
	e. Pn "r	P P	Efementary/Secondary (0-12)		(1-4or 5+)	life.	DO NOT use i	retired)	3				
7	e filed within 72 hours after deeth with the Maryland Hygiene. I other than "naturel", or iteme 23e or 28e-f ehow vent, the Madical Examiner must be notified at	Completed	12	0			lrug co	nsulor				ealth	care
בַ	be lied within 72 hours after deeth with the Marylan thy gione. d other than "nature!; or iteme 23e or 28e-1 show event, the Madical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last)						's Name <i>(Fir</i> s		aiden Suma	ime)	
<u>\sq</u>	should be nd Mentel marked c	၉	John Matthews						er Fla	99		O . 7	0.11
	C/ u = 6		19a. Informant's Name/Relationship (7					Street and Number			-		
e o	l end lealth im 27		Valerie Bruce/god 20a. Method of Disposition	daugh		10248		ory Ride	Road		Columb oc. Location		
0	Pages 1 nent of P int: If ite iry or ot		1 Burial 2 Cremation 3	Removal from		cemetery, crei	natory or othe	or place)			Jo. Location	· Ony or i	omi, otale
Ē	Pa tmen tant:		4 ☑ Donation 5 ☐ Other (Specify		1	1 0	. Al	Addison of Footba					
a a	permit. Page Depertment of Important: If any injury of ance.		21. Signature of Euneral Service Licen Ronal d S	Wade	Director			acomy Bo		55 W. I	Balti	nore :	Street
	00 = 6 Q		23a. Part1 Enter the diseese, or comp	CX	lu c			ce, MD 2		aratoni arros	••		Approximate
			shock, or heart failure. List only	one cause on	each fine.						»L,		Interval Between Onset and Death
í	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	Icute 1	myoc	ardia	Inta	rchôn				
	Examiner			Due to	o (or as a consec	juence of):		. I Infa	d. 100's	. 20			
		-	Sequentially list conditions, if any, leading to immediate	b. Due to	o (or as a consec	juence of):	e vu	success .	Chie	~ .			
	nsit	Ė	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										
·	exect n and ial-tra	Examiner	that initiated events resulting in death) Last	Due to	o (or as a consec	juence of):							
8760,	The law requires that the death certificets be executed sie has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	dlcat		d									
89	tifice g ph as th	ed	T										
Box	eath certific ettending p i for use as i	N/UE	IF FEMALE: 23b. Was decedent pregnant		utcome of pregnation		Ectopic preg	nancy				Date of defined	very Day Year
Э.	e dea he ett	Physician/Me	in the past 12 months?	4∐Pred 9☐Unk	gnant at time of o	death 5	Other (spec	ity)			"	nontri	Day 16a1
P. O.	at the	P.	9 Unknown	- 4 - 15 - 41 4 -	d = 45 b b a = 4 = = 4		- 4- 4- 4	an avven in Dort I	,	33a Did tobo	1000 1100 00	entributa to	the cause of death?
ŝ	uires that the der signed by the e Id be detached f	þ	Part II. Other significant conditions of	- 1	monam	20	sende /	Asthma	1		2 🗆 No		
5	w require been si should I	ted	Crivine	1	Mondie	(<u> </u>	7137760	_		1		
ec	elaw hasb je 2 st	Completed							2	24a. Was an autopsy perform	241	b. Were aut prior to condeath?	opsy findings available ompfetion of cause of
E	: The	ပ္ပံ							1		No.	1 Yes	2 🗆 No
<u> </u>	ilcian: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				10.	of Death (Che	. 4			
o	Phys this al dir	2	1 Yes 2 No 27. Manner of Death	1		28b. Time o		4 Nurs	sing Home	5 Resider			ıfy)
o D	ding Phys h. After this funeral di	盲	1 Natural 5 ☐ Pending		e of Injury onth, Day Year)	fnitury	м	: Injury at Work? 1 ☐ Yes 2 ☐ N					
Division of Vital Records,	i or Attending Physician: effer death. Director: After this certifice I in by the funeral director. I	flca	3 Suicide 6 Could not be	28e. Plac	ce of Injury - At h	ome, farm, st	reet, factory, o	office				n <i>ber or Rui</i>	ral Route Number,
2	efter Direction by	Certification:	4 Homicide determined	buit	lding, etc. (Speci	<i>fy)</i>				City or Town,	State)		
	To the Hospital or Attending Physician: The within 24 hours effer death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical C	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam	niner: On the	basis of examina	owledge, deat ation and/or in	h occurred at vestigation, in	the time, date and my opinion, death	d place, and d h occurred at	lue to the car the time, da	use(s) and te and place	manner as e, and due	stated. to the cause(s)
	ithin (ithin ed	29b. Signature and title of certifier	and ma	inner stated.		29c. l	icense number		29	d. Date sign	ned (Month	, Day, Year)	
	£ 3 ∓ 8			1 itd	eshi"			W3804	6				⊚ Waxter
•			30. Name and address of person who			m 23a) (Tyne		20 300		1	1000	Cathod	ral Street
				e dre	e street			mD zer	0/	В	altimore	e, Mary	and 21201
	Sta	ate	31. Date filed (Month, Day, Year)		Registrar's Sign		and o					·	
	Regist		NOV 0 9 20	06 1	BURN S	J. (4)							

			1 - For State Registrar	State of M	aryland / Depa <i>Cel</i>	artment of F		Mental Hy	giene 0	06	35408
	Physici	an	Decedent's Name (First, Middle, La William	F.	Kaline			2. Date of De Month	aath Day	Year	3. Time of Death
-	/Medi		4a. Facility Name (If not institution, giv				r . r Location of Deat	Novembe		006 nty of Deat	5:20P ^M
	Examir	ier	Washington Adven	tist Hospi	ta1	Takoma I	ark		Mor	itgome	erv
	Funeral		5. Social Security Number 6. S 216–16–8953	MAZM 2□F	ge (In yrs. last birthday) 83 Yrs.	Months Days	Hours Min.	(Month, Da	ay, Yea <i>r)</i>	9. Birtl	nplace (State or Foreign untry)
-	Director		Usual Residence of Decedent		03			Feb. 2	6,1923		MD
	yland		10a. State 10b. County		10c. City, Town or Lo	ocation					10d. Inside City Limits
	Mar iled	tor	MD Anne Aru	nde1	Brooklyn						1 ☐ Yes 2X No
	or 28	ire	10e. Street and Number			10f. Zip Code			10g. Citizen o	of What Co	untry?
	be filed within 72 hours after death with the Maryland hat Hygiene. od other then "natural", or items 23a or 28e-f ehow event, the Medical Examinar must be notified at	Funeral Director	5516 Patrick Hen	ry Drive		21225			U.S.A.		
	tems	une	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puer	Specify Yes or No to Rican, etc.)	o- 14. R B	lace - Ame lack, White	ncan Indian, e, etc.
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☒Widowed 4 ☐ Divorced	1 X Yes 2 ☐ If Yes, Give	No	1 ☐ Yes 2 🗓 No	Specify:		Spec		nite
21215-0036	hour turai	pa pa	15. Decedent's E	Year or Dates:	16a Dece	dent's Usual Occup	ation		16h Kind of		
5	in 72 in "na in dis	Completed	(Specify only highest gra	ade completed)	(Give	kind of work done	during most of wo	rking	16b. Kind of	DUSINGS S/I	ndustry
212	s with	E O	Elementary/Secondary (0-12)	College (1-4or	,	Worker			Beth1	ehem	Stee1
	should be filed within a Mental Hygiene. marked other then imatic event, the Mi	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Na	me (First, Middle			Dreet
<u>a</u>	Aental Aental rked o	To B	Bryan Kaline				Lydia	Wholey			
Maryland		ļ-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street			er, City or Tow	m, State, Z	ip Code)
	of Health of Health of Health of Item 27 i		Mr. William F. Ka	line Jr.	417	Fairfax A	venue Br	ooklyn,	MD 212	25	
Baltimore,	of He		20a. Method of Disposition 1 A Burial 2 Cremation 3	Removal from State	20b. Place of Dispo cemetery, crei	sition (Name of matory or other plac	Nov.	Date 7	20c. Location	n - City or	Town, State
Ĕ	Pa ant:		4 □ Donation 5 □ Other (Special		Glen Have	en Mem. P		06'	G1en	Burni	e, MD
at	permit. Pag Department Important: i any injury o		21. Signature of Funeral Service Lice	- A	10111	2. Name and Addre					me, P.A.
=	205 20		/Clau		'' 1	Second A	venue SW	Glen Bu	ırnie,	MD 21	061
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each li	ne.	Shock		c or respiratory a	rrest,		Approximate Interval Between Onset and Death
7	/Medical		resulting in death)	a. Due to (or as	a consequence of):	Shock					Hours
46.	Examiner		Constant line and deine	, Tatr	aconic 6	Right V	pontra	Mar Po	rforat	1nn	Hours
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):				1-1-6-1	.017	11
6	cate be executed physicien and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	· Taty	ogenic t	ertora-	tion of	LAD			Hours
9,	e exe	EX	resulting in death) cast	Due to (or as	a consequence of):						
8760,	cate b	dicai		d							
9	entific ding p	/Me	IF FEMALE:	220 If you outcome	of programme.						
Вох	The law requires thet the death certificate has been signed by the ettending I agge 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal death 3	Ectopic pregnancy	,			Date of delin Month	very Day Year
o.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	t time of death 5L	Other (specify)					
<u>α</u>	that the de led by the e detached t		Part II. Other significant conditions	contributing to death b	out not resulting in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco use co	ontribute to	the cause of death?
Vital Records,	uires sign d be	d by	Emergency re	Parrol	Fright 1	pintreul	10	10	Yes 2 □ No	3 ☐ Pro	bably 4 Dunknown
Sol	w requir been s should	Completed	laceration		111111111111			24a. Was	241	Wore put	tongy findings mystable
Re	The lav	du	laceration					auto	psy ormed?	prior to c death?	opsy findings available ompletion of cause of
ā		e Cc	25. Was case referred to medical				00 Pl(P	1 ☐ Yes	2 2 No	1 🗌 Yes	2 No
>	Physician: this certificanal director.	0 8	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ent 2 ☐ ER/Outpatier	nt 3 DOA Oth	or	ath <i>(Check only d</i> dome 5 🗆 Resi		ther /Spec	
o	eral c	ı.	27. Manner of Death	28a. Date of Inju	ry 28b. Time of			28d. Describe			ny)
Division	Attending in death.	atio	1 Matural 5 ☐ Pending 2 ☐ Accident investigatio	(<i>Month</i> , <i>D</i> a	y Year) Injury		K? Yes 2 □ No				
Vis	ar de	tific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of In	ury - At home, farm, str	eet, factory, office		28f. Location (nber or Ru	ral Route Number,
Ö	s afte	Certification:	Tioniodo	building, et	ic. (Spacity)			Oily or 10	wii, State)		
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	edical	(Check only 2 Medical Exal	miner: On the basis o	of my knowledge death	vestigation, in my o	ne date and place pinion, death occu	and due to the urred at the time,	cause(s) and date and place	namer as	to the cause(s)
	thin 2 the mplet	Med	29b. Signature and title of certifier	and manner st	ated.	29c. Licens			29d. Date sign		
	T ¥ I		SSS. Signature and this of certified	0	(1)				-		
	1		I Wing		(1)	136	07		Novem	iber	3,2006
	6		30. Name and address of person who Thomas Militano 7			•	comp Dowl	, MT)			
	Sta	to.	31. Date filed (Month, Day, Year)		rar's Signature	4	noma fäft	ς, III			
2.54	Dogist	TIC .		2005	M. A.	acrace B					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 35409 Amend Items State of Maryland / Department of Health and Mental Hygiene (1) (1) 6

Amend Items 25,28a,e,f per MF. (361,11/09/06dhb

Certificate of Death

Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 11:20 PM Annie Frances Lee 28,2006 CCTOBER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BAUTIMORE
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. SAINT AGNES HUSPITAL 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1□M 2ਊF 71 Director 217-30-3506 14, Maryland Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f ahov other than "natural", or items 23a or 28e-f ahov MD Baltimore 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1046 N. Ellamont Street 21216 by Funeral USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X]No ff Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. unk 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: black 3 ☐ Widowed 4 ☐ Divorced Completed 15 Decedent's Education 16a. Decedent's Usual Occupation unk 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 0 domestic traumatic avant, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: if Item 27 is marked oth any lightly or other traumatic avent pixe. 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Sumame) Be Mildred Gunther 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anita Inabinette/daughter 1046 N. Ellamont Street Baltimore, MD 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Suneral Service State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardial or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) CENTRON APPROVED BY MEDICAL EXAMINER Pnysician INTRA CEPEBRA 24 hrs /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): the attending physicien Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Dav Year 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown has been signed by Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Records. The law requires 2 2 No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' this certificete 1 Yes 2 No 1 ☐ Yes 2 No Division of Vital Attanding Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitaf: Medical Certification: To 1 Yes ZUNO Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28a. Date of Injury 10/27/2006 28b. Time of fnjury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 1No death. UNKNOWN FALL AT HOME 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours after To the Funeral Direct 1046 N. Ellamont St., Balto., MD 4 Homicide Hospital or 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) asu P-9170 OCTOBER 28,2006 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) mp 900 CATON AVENUE, BALTIMORE, mp, 2122 asmu Hamuen 31 Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

NOV

0 9 2006

GOODEN !

35410 State of Maryland / Department of Health and Mental Hygien [] Certificate of Death 2. Date of Death Day 7, 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 2006 10:30PM November Wendy Jean Lyons /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Westminster Carroll Hospital Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day, Year) | Feb 2, 19 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Funeral 1□M 2⊠F 217-34-7133 Yrs. 69 Director 1937 New York Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County Item 27 is marked other then "naturel", or items 23s or 28s-1 show other traumatic event, the Modical Examinar must be a culting at 1 Yes 20No MD Carroll Westminster Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with innent of Health and Mental Hygiene.
Int: If Item 27 Ie marked other then "naturel", or Iteme 23a or UInited States 1306 High Earls Ct. 21158 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify: 3 Widowed 4 Oivorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) American Space 12th Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Planners Be Paul Albert Blum Margaret Raymond 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21157 Susan Haddaway (daughter) 20b. Place of Disposition (Name of cametery, crematory or other place)

Westminster,

MD 21157

20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ŏ permit. Page Department of Important: If any Injury or Meadowridge Mem Park 11/10/2006 Elkridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility 21. Signature of Funeral Service Livensee

Burrier—Queen Funeral Home and Crematory, P.A.

1212 W. Old Liberty Rd. Will field, Approximate Interval Between Shock, or heart failure. List only one cause on each line. Immediate Cause (Final COPD and stage 24eors **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last Due to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) attending physicien Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Year Day 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 Yes 2 No 3 Probably 4 Minknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? filled in by the funeral director, 26. Place of Death (Check only one) Hospital: 1 Depatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medicai Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 🖂 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Fune completely fi 2 Medical Examiner: On the basis of assumation and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 52035 2006 Nov 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

B (NI) CHACK 291 S Forey Wenne MO 2/157 Westminister Stoner CHACK 31, Date filed (Month, Day, Year) 32. Begistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

	•	1- For State of Maryland / Department of Health and Registrar Certificate of Death	d Mental Hy	rgiene 006	35411
Physicia	-	Decedent's Name (First, Middle, Last) STEPHEN D. LAROCCA	2. Date of Do Month NOVEM	Day Year	3. Time of Death 10:45 A.M
/Medic Examin	40	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of D BLUEPOINT NURSING HOME BALTIMORE CITY	eath	4c. County of Dea	
Funeral Director		215-94-1079 42 Yrs.	Vin. (Month, D.	ay, Year) C	rthplace (State or Foreign ountry) IEW YORK
Maryland f ehow	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD BALTIMORE PARKVILLE			10d. Inside City Limits 1 ☐ Yes 2 ☐Xio
with the N 3e or 28a-	i Director	10e. Street and Number 10f. Zip Code 2111 WILKER AVENUE 21234		10g. Citizen of What C	ountry?
Ind 21215-0036 Ind within 72 hours after death with the Maryland tal tygiene. It bygiene. It of hygiene of thems 23s or 28s-f show event, it a Medical Examinar must be notified at	by Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin' If Yes, specify Cuban, Mexican, Proceeding the Process of the Proces	? (Specify Yes or Notuerto Rican, etc.)		te, etc.
Maryland 21215-0036 d2 should be filed within 72 hours aft this and Markel Hygiens 77 is marked other then "natural", or traumatic event, it a Medical Eventitional properties of the market of the ma	Completed		working	16b. Kind of Business	
yland 2 buid be filed Mental Hygi arked other	To Be Co	17. Father's Name (First, Middle, Last) EDMUND LAROCCA PATI	RICIA MAC	e, Maiden Sumame) KIE	
		19a. Informant's Name/Relationship (Type, Print) DEBRA L. AGUDELO/SISTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	BALTIMOR Date		4
Baltimore, permit. Pages 1 ar Department of Hea Important: If Item eny injury or other soce.		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) METRO CREMATORY, INC. 1 21. Signature of Funeraf Service Licensee 22. Name and Address of Facility **Hell Hunt Hunt 8521 LOCH RAVEN II		CATONSVILL	/
Physician /Medical Examiner physician and the price price physician and the price physician structure physician structure physician and the price physician structure physician	dicai Examiner		o Company	Ryno	Approximate Interval Between Onset and Death
	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. ff yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown		23d. Date of de Month	l Day Year
rds, P.	by	Pare in Comer significant conditions continuously to dealer but not resulting in the underlying cause given in Pare in		tobacco use contribute t	to the cause of death?
al Reco	Completed		24a. Was auto perf 1 \(\text{Yes}	s an ppsy prior to death? No 1 Ye	utopsy findings available completion of cause of
Division of Vital Records, P.O. Box 6: To the Hospital or Attending Physician: The law requires that the death certific within 24 hours elfer death. To the Fundaral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Certification: To Be	examiner? 1 Yes You Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursin	28d. Describe	one) idence 6 Other (Special Number of Figure 1) (Street and Number of Figure 2)	· ·
Divisic Othe Hospital or Attend within 24 Hours etter divisions and injectors. Completely filled in by the it	edical Ce	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and p 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death of and manner stated.	place, and due to the occurred at the time	cause(s) and manner a , date and place, and du	s stated. e to the cause(s)
To the within To the Comp	Me	29b. Signature and title of certifier 29c. License number	,80	29d. Date signed (Mon	th, day, Year)
Sta	to	30-Name and address of person who completed cause of death (Rem 38a) (Type, Print) 31. Date filled (Month, Day, Year) 32. Spistrar's eignature,	Bolt	more)	Nonglan
Registr		MANY A A COOR			,

	1	For State Registrar	State of Mar	yland / Depa <i>Cer</i>	artment of He tificate of D			ene 0	06	35412
Physicia	an	Decedent's Name (First, Middle, Last)		L	ANE-EPPS		2. Date of Death Month November	Day 4	Year	3. Time of Death
/Medic Examin		LESLIE 4a. Fecility Name (If not institution, give str THE JOFINS HOPKINS HOSE			4b. City, Town, or I		THO TELL SEA		y of Death	
Funeral Director		5. Social Security Number 6. Sex		(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 10/23/1	^(ear) 949	Coui	place (State or Foreign ntry) HIO
Maryland a-f ehow	ctor	Usual Residence of Decedent 10a. State 10b. County DELAWARE		10c. City, Town or Lo						10d. Inside City Limits 1 √ Yes 2 □ No
with the 3a or 28	il Director	10e. Street and Number 149 BALTURSOL ROA	AD		10f. Zip Code 19901		10	g. Citizen of US	SA	ntry ?
filed within 72 hours after death with the Maryland Hygiene sther then "naturel", or iteme 23a or 28a-f ehow sith the Medical Examinational beneaffled at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	,	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 ☑ No	spanic Origin? (Spo h, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	ВІ	ace - Ameri ack, White, ^{ify:} BLA(, etc.
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Heelth and Mental Hygiene. Department of Heelth and Mental Hygiene important: if Item 27 is marked other then "naturel", or Items 23a or 28a-f ehow important: if Item 27 is marked other then "hadical Examinational be notified at single."	Completed I	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+	(Give	dent's Usual Occupa kind of work done di DO NOT use retired)	uring most of work		6b. Kind of		ndustry IRLINES
be filed water the other the other the	Be	17. Father's Name (First, Middle, Last) EARL LANE	66	AL	DMINISTRAT	18. Mother's Name		laiden Suma		
d 2 should be th and Mental t7 ie marked c traumatic ev	1	19a. Informant's Name/Relationship (Type BRIAN MARTIN / COU			ng Address (Street a					
Pages 1 and nent of Heelth int: If Item 27 iry or other to		20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)		20b. Place of Dispo cemetery, cre Me+	matory or other place	a)	Date 2	Oc. Location	•	
permit. F Departm Importar any injur		21. Signature of Funeral Service License	Whorte	2:	2. Name and Addres	RENS ST.	, BALTO.	, MD_2		S F.H., INC
Physician /Medical Examiner		23a. Party. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	ACUTE	the death. Do not ene. LYMPHOCHTIC a consequence of):	1		or respiratory arre	51,		Approximate Interval Between Onset and Death Months
cate be executed physicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		consequence of):						
ath certifi ttending I or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⊠ No 9 □ Unknown	3c. If yes, outcome of the control o	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)				Date of deli	very Day Year
uires that the designed by the a	5	Part II. Other significant conditions con	tributing to death bu	ut not resulting in the	underlying cause give	en in Part I.		acco use co		the cause of death?
The law requir te hes been si age 2 should	Completed						24a. Was a autops perform	Y	b. Were au prior to d death? 1 🗆 Yes	itopsy findings available completion of cause of 2 No
sician: certifica rector, p	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2⊠ No	ospital:	nt 2□ER/Outpatie	ent 3 DOA Oth		th <i>(Check only on</i> ome 5 ☐ Reside		Other (Spe	cify)
To the Hospital or Attanding Physician: The tay within 24 hours efter death. To the Funarel Director: Attacthis certificate hes completely filled in by the funeral director, page 2	atlon: To	27. Manner of Death 12. Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Da)	y 28b. Time	of 28c. Injur		28d. Describe ho			
al or Atter s efter dea si Director ad in by the	Certification:	3 Suicide 6 Could not be determined	building, etc				City or Towi	n, State)		ural Route Number,
Hospital or 24 hours efte Funerel Dir etely filled in I	edicai (29a. Certifier Check only one) Certifying Physical Cartifying Phys	sician: To the best of ner: On the basis of and manner sta	of my knowledge, dea examination and/or inted.	ath occurred at the tir investigation, in my o	me, date and place pinion, death occu	, and due to the c rred at the time, d	ause(s) and ate and plac	manner as e, and due	s stated. e to the cause(s)
To the I	Mec	29b. Signature and title of sertifier	,		29c. Licens					h, Dey, Year)
	6	30. Name and address of person who co	empleted cause of d	eath (Item 23a) (Type	e, Print)			YOVEMB	ER 4	, 200 G
1		DAVID GERBER	MD	ar's Signature	OLFE STRE	ET BA	LTIMORE,	MD	21209	5
S Regis	tate trar	31. Date filed (Month, Day, Year) . NOV 0 9	32. He str	ar a Signature	And I					

			For Stata Registrar		State of	f Marylan		artment of H			ntal Hygie	711116	35413
			Decedent's Name (First, Middle, Las	t)	·		· · ·		2.	Date of Death		3. Time of Death
	Physici /Medio		JAME	5			LE	NE		0	Month	Day Year 28 2004	3:51AM
-	Examir		4a. Facility Name (If n	ot institution, give	street and nur	nber)		4b. City, Town, or				4c. County of Dea	
			NORTHW	EST 14	OSPITAL	_		RAND	ACCS	700	N	BACT	MORE
	Funeral		5. Social Security Nur	nber 6. Se		7. Age (In yrs.		If Under 1 Year Months Days	If Under Hours	Min.	Date of Birth (Month, Day, Ye	9. Bi	rthplace (State or Foreign ountry) unk
	Director		212-56-786	59	M 2□F	55	Yrs.			N	ov 4, 19	950	
	and		Usual Residence of D 10a. State	ecedent 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
	f sho	ō	MD	Balti	nore		Randa	11stown					1 ☐ Yes 27 No
	the !	Director	10e. Street and Numb					10f, Zip Code			10g.	Citizen of What C	ountry?
	3a or		10301 Mar	riottsv:	ille Ro	ad			2113	33		USA	ŕ
396	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23e or 28e-f show amy injury or other traumatic event. If a Medical Exp. other must be notified at ance.	by Funeral	11. Marital Status 1 Never Married 3 Widowed 4		12. Was Dece Armed Fo 1 Tyes If Yes, Giv Year or D	217 No		Was Decedent of Hi f Yes, specify Cuba 1 □ Yes 2∑ No	spanic Ori n, Mexicar Specify:	n, Puerto Ric	y Yes or No- an, etc.)	14. Race - Am Black, Whi	ite, etc.
ŏ	2 hou	ted	1	5. Decedent's Ed	ucation		16a. Dece	dent's Usual Occupa	ation		unk 16t	o. Kind of Business	s/Industry unk
21215	d within 7 giene. ir then "n ir e blood	Completed	Elementary/Second unk		College (1	-4or 5+)	life.	kind of work done o DO NOT use retired	ou <i>nng</i> mos ()	st of working			
land	id be file lental Hyg ked othe ic event,	To Be C	17. Father's Name (F)	irst, Middle, Last)				unk	18. Mothe	er's Name (F	irst, Middle, Mai	den Sumame)	unk
ary	shou and M mar umat		19a. Informant's Nam	ne/Relationship (7	ype, Print)		19b. Mailir	ng Address (Street a	and Numbe	er or Rural F	oute Number, C	ity or Town, State,	Zip Code)
Σ	and 2 allth a 127 I		Northwest	Hospita	1		5401	Old Court	t Roa	d Rand	lal1stow	n, MD 21	1133
Baltimore, Maryland 21215-0036	Pages 1 ment of He ant: If iten ury or oth	8	20a. Method of Dispo 1 Burial 2 4 Donation 5	Cremation 3 ☐	in st	State C	Place of Dispo emetery, crer	sition (Name of natory or other plac	θ)	Date	200	c. Location - City or	r Town, State
Balt	permit. Depart import eny inj ens inj		21. Signatura Fune	eral Service Licen	Wade,	irector		Name and Address ate Anato			55 W. B	altimore	Street
			23a. Part . Enter the shock or heart	disease, or comp failure. List only	olications that cone cause on e	aused the deatl					espiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Fi	inal	a.	SE	P51	5					Onset and Death
	/Medical Examiner		resulting in death)		Due to	or as a conseq	uence of):						
	uted d ansit	Examiner	Sequentially list cond if any, leading to imm cause. Enter Underly Cause (Disease or in that initiated events	nediate ying jury	Due to	or as a conseq	uence of):						
8760,	ate be executed hysician and the burial-transit	dical Exa	resulting in death) La	st		or as a consequ	uence of):						
687	ificate g phys as the	edic			. u.								
.О. Вох	The law requires that the death certific tie has been signed by the attending pi tage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent p in the past 12 m 1 ☐ Yes 2 ☐ I 9 ☐ Unknown	onths?	1 Live b	come of pregna irth 2 Feta ant at time of do own	death 3	Ectopic pregnancy Other (specify)				23d. Date of de Month	olivery Day Year
ds, P.	uires that signed by lid be deta	<u>م</u>	Part II. Other signific	ant conditions of	ontributing to de	eath but not resi	ulting in the u	nderlying cause give	en in Part I	l.	23e. Did tobac		to the cause of death?
Division of Vital Records,	The law requirence to the law requirence has been size page 2 should	Completed									24a. Was an autopsy performed	d? death?	utopsy findings available completion of cause of
ta		a)	25. Was case referre	d to medical		8/			26. Place	e of Death (C	Check only one)		
>	ysician: ils certifice director, p	To B	examiner?	•	Hospital: 1 👊	patient 2 🗆	ER/Outpatier	nt 3 DOA Othe				e 6 □Other (Spe	ecify)
0	ding Ph. h. After thi funeral		27. Manner of Death	5 □ Ponding	28a. Date	of Injury th, Day Year)	28b. Time o		/ at		I. Describe how i		
Ö	Attending Physician: r death. sctor: After this certification by the funeral director.	atlc	2 Accident	5 Pending investigation		, , , , , , , ,	,,		Yes 2□	No			
O N N	tel or Attendest is after desti al Director: ed in by the	Certification:	3 ☐ Suicide 4 ☐ Hornicide	6 Could not be determined	286. Place	of Injury - At ho ng, etc. (Specify	ome, farm, str y)	eet, factory, office		28f	Location (Stree City or Town, S	t and Number or R tate)	lural Route Number,
	To the Hospitei or At within 24 hours after or To the Funeral Directompletely filled in by	Medical (29a. Certifier 1 (Check only 2 one)	Certifying Ph	niner: On the b	asis of examina ner stated.	wledge datil tion and/or in	h consumed at the tim vestigation, in my of	na date an pinion, dea	nd place and ath occurred	I due to the caus at the time, date	c(s) and manner a and place, and du	e to the cause(s)
)	To the within 24	ž	29b. Signature and tit	/		. 4	٥,	29c. License		2_		Date signed (Mon	
			30. Name and 13 res	ss of person who	completed caus	se of death (Item	1 23a) (Type,	Print) NORT	HWE	st Ho	SPITAL C	ENTER	28 2006
			LEONARD (540	1 040	COURT	RUAP	RAN	PALLSTU	WN MD	21133
	Sta		31. Date filed (Month,	Day, Year)	32. A	egistrar's Signa				(
	Regist		NOV	0 9 2006	133	the As	Som	8 3	<u>-</u>				
DHI	MH 17 Rev 1/2	001			Contract of the contract of th		A						

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 006 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Yeer **Physician** ALEXANDER MCFALL 11 · 04 · 6:15 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner NA FUTURE CARE IRVINGTON BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 M 2 □ F 248.62.4283 Yrs. Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "naturel", or items 23a or 28a-f show other treumatic event, it a Madical Examiner must be notified at 1 R Yes 2 No Director MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1006 N. AUGUSTA AVENUE 21229 USA death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ■ Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify: BLACK ≥ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life_DO NOT use retired) 12 should be filed within he and Menfal Hygiene.
7 le marked other then ** Elementy CRADEry (0-12) College (1-4or 5+) IRUCK DRIVER NIA 12-11 GRADE TRUCKING COMPANY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) UNK OTIS MCFALL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ant: If item 27 is JUDY MCFALL (WIFE 1006 N. AUGUSTA AVE. BAITIMORE MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other place)
SANDY GROVE Dale 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State ŏ Department of important: If arty injury or gree. 4 ☐ Donation 5 ☐ Other (Specify) MISSIONARY BAPT. CHURCH 11.11.06 BENNETTS VILLE, SC 21. Sign ture of Funeral Service Licenses 22. Name and Address of Facility VAUGHN C. GREENE FUNERA SERVICE 5151 BALTO. NATI PIKE, BALTO, MO 21 Vanghn 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leaf failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Toj/we Due to (or as a consequence of): **Physician** Few week /Medical Examiner Stage COPD Mon Thy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ed by the attending physician and defached for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 4□Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown 9 Unknown certificete has been signed by rector, page 2 should be defach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Concer 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification; 28c. Injury at Work? 28d. Describe how injury occurred Hospitel or Attending 24 hours after death. Affer 1 Natural 5 Pending 2 Accident investigation M 1 Yes 2 No Director; 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicide To the Hospitel of within 24 hours all To the Funeral D 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8/06 Do062634 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TIEBN ACVAN COLUMBIA 21044 10802 HICKERY RIDGE RUAD MO 31. Date liled (Month, Day, Year) 22. Registrar's Signature State NOV 0 9 2006 12 150 Registrar

ALEXANSOER

				artment of Health and Men [.] <i>rtificate of Death</i>	tal Hygiene 0	16 35415
Š	Physici	an	Decedent's Name (First, Middle, Last) Millard Moody Sr.	N.	Date of Death Month Day	3. Time of Death
	/Medic Examir	-	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County o	of Death
4	Funeral		Frince George's Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. 8, D	ate of Birth	e George's 9. Birthplace (State or Foreign
轻	Director		224–38–7856 1 ★ 2 ☐ F 73 Yrs.	Months Days Hours Min. 12	Month, Day, Year) /24/1932	Country) VA
	iryland thow		10a. State 10b. County 10c. City, Town or Let VA Chesape			10d. Inside City Limits
	the Ma 28a-f	recto	10e. Street and Number	10f. Zip Code	10g. Citizen of W	1 Yes 2 No
	ath with	Funeral Director	1322 Sunnybrook Terrace	23321	USA	
9036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 te marked other then "netural", or Items 23a or 28a-f ehow or other traumatic event, Ita Medical Examinar must be notified at	by	Armed Forces? 1 ☐ Never Married 2 ☑ Married 1 ☒ Yes 2 ☐ No	Was Decedent of Hispanic Origin? (Specify` If Yes, specify Cuban, Mexican, Puerto Ricar 1 ☐ Yes 2 ☎No Specify:		- American Indian, ; White, etc. Black
21215-0036	in 72 h	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working DO NOT use retired)	16b. Kind of Bus	iness/Industry
212	filed with Hygiene. other the		12	ic School Teacher		School System
land	uld be fil fental H rked oth tic even	To Be	17. Father's Name (First, Middle, Last) George Moody	18. Mother's Name (First Daisy You	st, Middle, Maiden Surname ng)
, Maryland	1 and 2 should I Health and Meni Iem 27 Ie marke othar traumatic			ng Address (Street and Number or Rural Rou Sunnybrook Terrace,		
Baltimore,	permit. Pages 1 an Department of Heal Important: if Item 2 eny injury or other Once.		4 Donation 5 Other (Specify) Gard	n Memorial 11/11/2 ens	2006 Chesapea	
Ball	Depart Import eny in		21. Signature of Funeral Service Licensee	2 Name and Address of Facility harles L. Stevens Fu 201 East Fort Avenue	neral Home In , Baltimore,	nc. MD 21230
.*			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.			Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Arterios Ceutr Due to (or as a consequence of):	c Hypertansive 1	Heart Dise	ese
1	Examiner	-	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
. ور	acuted ind transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c			
68760,	ificate be executed g physician and as the burial-transit	edical Ex	Due to (or as a consequence of):			
× 68	ertificat ling phy e as th		IF FEMALE:			
.O. Box	To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	by Physician/M		□Ectopic pregnancy □ Other (specify)	23d. Date Mont	of delivery th Day Year
ords, P.	equires that en signed t		Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacco use contrib	oute to the cause of death? B Probably 4-Unknown
Division of Vital Records,	: The law r cete has be , page 2 sh	Completed			autopsy pri performed? de	ere autopsy findings available for to completion of cause of eath? Yes 2 No
<u>=</u>	s certif	To Be	25. Was case referred to medical exampler? H☐Yes 2☐No Hospital: 1☐Inpatient 2☐ER/Outpatien	26. Place of Death (Che	eck only one) 5 ☐ Residence 6 ☐ Other	(Spaciful)
ou o	nding Phy tth. : After thi e funeral		27. Manna of Death 1- Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Injury		Describe how injury occurred	
Divis	al or Atte s after des al Director ad in by th	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, streaming building, etc. (Specify)	eet, factory, office 28f. L	ocation (Street and Number City or Town, State)	r or Rural Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, and d vestigation, in my opinion, death occurred at	lue to the cause(s) and manuthe time, date and place, an	ner as stated. nd due to the cause(s)
)	To T Com	Σ	29b. Signature and title of certifier A 2 - 1 - 1 - 1 - 1 - 2 - 2 - 2 - 2 - 2 -	29c. License number	29d. Date signed	(Month, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type. SALVADOV SLIVATOV 309 HOSD). 7	Print Dring Charel	R Kan 1-	1, -000
	Sta		31. Date filed (Month, Man (Vear) 9 2006 32. Registrar's Signature	andis	Jan June	2 9
8	Registr	ar	and the state of t			

			1 - For Stata Registrar		aryland		artment of F tificate of		Mental Hy	giene Rag. No.	006	35416
	Physic /Medi			Marshall					2. Date of De Month 11/06	Day 5/2006	Year	3. Time of Death 5:10pM
	Examir	ner	4a. Facility Name (If not institution, giv 707 Maiden Choice		t.8106		4b. City, Town, or Catons		ath		ounty of Death	9
	Funeral Director		130-20-3304	ex 7. Ag □ M 2.23%F	e (In yrs. last 93	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hi Hours Mi		th ly, Year) L913	9. Birthp Coun	lace (State or Foreign htry)
Pool of the Control	f show	ō	Usual Residence of Decedent 10a. State 10b. County MD Baltimo	re	10c. City, T		cation ensville				1	0d. Inside City Limits 1 X Yes 2 □ No
1 1 1	3a or 28a	al Director	10e. Street and Number 707 Maiden Choice	Lane, Apt	.8106		10f. Zip Code 2122	B		10g. Citize	n of What Coun	itry?
d 21215-0036 filed within 72 hours after death with the Mandadd	lal Hygiene. dother then "natural", or liems 23a or 28a-f show event, it a Medical Examinar must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ★ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:			Vas Decedent of H Yes, specify Cuba ☐ Yes 2 1 No	ispanic Origin? n, Mexican, Pue Specify:	(Specify Yes or No erto Rican, etc.)]	Race - Americ Black, White, pecify: Whit	etc.
1215-0036	then "nature	Completed	15. Decedent's E. (Specify only highest gra	de completed) College (1-4or 5		(Give life. L	ent's Usual Occupa kind of work done o OO NOT use retired	during most of w	orking		of Business/Inc	dustry
Maryland 2	and Mental Hygier s marked other th	To Be Co	12 17. Father's Name (First, Middle, Last) Joseph H. Sulge			Home	maker	18. Mother's Na Margare	ame (First, Middle,		mame)	
	h ar		19a. Informant's Name/Relationship (Carole Moffitt /		1		g Address (Street a					
בַ בַּ	- ± 5		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🕱 4 ☐ Donation 5 ☐ Other (Specify				sition (Name of latory or other place Cemetery	11/0	Date 09/2006		tion - City or To	,
Ball	Department important: If any injury or once.		21. Signature of Funeral Service Licer	Maysh	all	12	Name and Addres arles L. 01 East 1	ort Ave	enue, Bal	timor	Inc. e, MD 2	1230
	hysician Medical xaminer		23a. Part1. Enter the disease, or com, shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	olications that caused one cause on each ling a	590	ramo	or the mode of dying			rest,		Approximate Interval Between Onset and Death
ficate be executed	physician and is the burial-transit	edical Examiner	Sequentially list conditions, Tay, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a d.								
the death certifica	within 24 hours efter death. To the Funeral Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the	Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 🗌 Fetal déa	ath 3⊡	Ectopic pregnancy Other (specify)			23d	. Date of deliver Month	y Day Year
V requires that	en signed t	Ď	Part II. Other significant conditions of	ontributing to death bu	it not resulting	g in the un	derlying cause give	n in Part I.	23e. Did to	- 1-1		e cause of death?
The law re	cete has be	Completed								an 2 sy med? 2127No	4b. Were autop prior to com death? 1 \(\text{Yes} \) 2	sy findings available pletion of cause of
V IL	certif	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 € No	Hospital:			3C DOA Othe		ath Check only o	100		
nding Phy	ath. r: After this re funeral d	J	27. Manner of Death Natural 5 Pending Pe	1 ☐ Inpatier 28a. Date of Injur (Month, Day		outpatient b. Time of Injury	28c. Injury Work	+ Li Nuising i	Home 5 Resid)
ital or Atte	rs efter de ral Directo led in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc	ry - At home, . (Specify)	farm, stre	et, factory, office		28f. Location (S City or Tow	treet and Ni n, State)	umber or Rural	Route Number,
the Hosp	hin 24 hou the Fune apletely fil	Medical	one)	vsician: To the best of iner: On the basis of and manner state	examination a	lge, death and/or inve	estigation, in my op	inion, death occ	urred at the time, o	late and pla	ce, and due to	the cause(s)
J.	To cor	-	29b. Signature and title of eertifier	- MD			29c. License	TT >			gned (Month, D	ay, Year)
	5		30. Name and address of person who co	ompleted cause of de	eath (Item 23a		rint)	iaw	Catu	10 Vei	ann ()	1,2001
	Sta Registra		31. Date filed (Month, Day, Year)	2006 32. Redistra	r's Signature		Call Co			41		7

Registrar DHMH 17 Rev 1/2001

State

Span !

PU ILTE IL

2006

32. Registrar's Signature

MICHAIL

31. Date filed (Month, Day, Year)

06-08363 Lee McDuffie

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 35418

		1- For State Registrar	Cert	tificate of D	eath	Re	2 U eg. No.	00 3341
Physicia		Decedent's Name (First, Middle,Las				2. Date of Deat	th	3. Time of Death
edical Exami	ner	4a. Facility Name (if not institution, give	McDuffie	JR.	City, Town, or Location of De	Month November		1308 hrs
J		St. Agnes Hospital	s street and number)		altimore	atn	4c. County of De	ath
Funeral		5. Social Security Number 6. Se	ex 7. Age (In yrs. las	st birthday) If	Under 1 Year If Under 24	Irs. 8. Date of Bir	th(MM/DD/YYYY) 9.	
Director		220-88-2121 1X	M 2 F 39	Yrs.	Months Days Hours N	in. 07/25	/1967 For	eign Country) SC
		Usual Residence of Decedent				0 1780	71101	
w any		10a. State 10b. County	10c. City, T	Town or Location				10d. Inside City Limits
Maryland 28a-f show d at once.	tor	MD Baltime	ere Lar	dsdown				1 Yes 2 No
e Mar or 28a	Director	10e. Street and Number		10	f. Zip Code		0g. Citizen of What C	ountry?
with the Maryland ms 23a or 28a-f sho be notified at once		248 Green Fer	12. Was Decedent Ever in U.S		ecedent of Hispanic Origin? (15.A	erican Indian, Black,
eath v item	Funeral	1 Never Married 2 Married	Armed Forces?		specify Cuban, Mexican, Pue		White, etc	
21215-0036 Uld be a filed with the Maryland Mana Flied with the Maryland Mana Flied with Typiens after death with the Maryland marked other than "natural", or items 23a or 28a-f she event, the Medical Examiner must be notified at once	by Fu	3 Widowed 4 Divorced	1 Yes 2 No	1 Yes	s 2 X No specify:		Specify: B	ack
hours:	eted b	15. Decedent's Education (Specify or			Isual Occupation (Give kind of working life, DO NOT use r		16b. Kind of Busines	ss/industry
36 in 72 l	plet	Elementary/Secondary (0-12)	College (1-4 or 5+)	^		ourou)		
5-0036 iled within 72 Hygiene. J other than '	Compl	17. Father's Name (First, Middle, Last)		Care	Assistant 18 Mother's Na	me (First, Middle, N	State of	Maeyland
21215-0036 Uld be filed within 7 Mental Hygiene. marked other than	Be	Lee J. McDuf			Lillie	Ann	Tomlin	
2121 ould be fil d Mental I s marked lic event,	Tof	19a. Informant's Name/Relationship (T		19b. Mailing Ad	dress (Street and Number of	or Rural Route Num	nber, City or Town, St	ate, Zip Code)
e, MD 2 I and 2 should Health and M Fitem 27 is m		Theresa Hazelwa		248 GR	Leen Fern Way		down MD	31337
nore, ages lar nt of Hee nt: If ite		20a. Method of Disposition 1 X Burial 2 Cremation 3		lace of Disposition ematory or other p	(Name of cemetery, blace)	Date	20c. Location - City	or Town, State
[남룡 윤 윤 교		4 Donation 5 Other Specify:	M+.	Zipn C	enetery 111	10/2006	Baltimos	e, MD
Baltimo permit. Pag Department Important: Injury or o		21. Signature of Funeral Service Licen	see	22. Name	and Address of Facility	Fureral	SVL	
Physician		23a. Part I. Enter the disease, or comp	lications that caused the death.	15151	Balto North P	Re Kalt	more mi	Approximate Interval
/Medical		failure. List only one cause on ea	ich line.					Between Onset and Death
Examiner		Immediate Cause (Final disease a. or condition resulting in death)	Thrombosis, Left : Due to (or as a consequence of):	chest tra	scending artery	complicati	re probable	Dod.ii
	_	Sequentially list conditions, b.			Tunia			
	ine	cause. Enter Underlying Cause	Due to (or as a consequence of):	•				1
d Sit	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):	:				
xecuted π and - transit		d.	1					
760, icate be ex physician the burial	/Medical				ME, g862, 12/14/	'06 TT	-	
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna	ancy ₂ Fetal d	eath 3 Ectopic preg	nancy	23d. Date of delive	ery Day Year
Box 68 c death certif the attending	sicis	1 Yes 2 No 9 Unknown	4 Pregnant at time of		(Specify)			
the de	Physician	Part II. Other significant conditions	9 Unknown	culting in the under	dving cause given in Port I	23e Did to	hacco use contribute	to the cause of death?
P.C s that gned be detail	ē	and the contract of the contra	contributing to death but not res	salang in the under	Tyring couse given in rait i.			robably 4 V Unknown
ds, equire	Completed				· · · · · · · · · · · ·	- 24a. Was a	an 24b. Were	autopsy findings available
e law	d H					autop:	med? death	
n: The		25. Was case referred to medical			26.Place of Death (Chec	1 Yes	2 N 1 🗸	Yes 2 No
Division of Vital Records, P.O. Box 68 and or Attending Physician: The law requires that the death certif is after death. al Director: After this certificate has been signed by the attending led in by the functal director, page 2 should be detached for use as	o Be		Iospital: 1 Inpatient 2 🗸 E	ER/Outpatient 3	Other:		Residence 6 Ott	ner:
n of V ding Ph.	\vdash	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe h	now injury occurred	
ion Itendi leath. tor: /	atio	1 Natural 5 Pending 2 Accident Investigation	End 11 // /2006	Fnd 9:35 an	1 Yes 2 No	unknown		
Division pital or Attenc ours after death oral Director: filled in by the	Certification:	3 Suicide 6 Y Could not b	28e. Place of Injury - At hom			28f. Location (S or Town, S	Street and Number or late)	Rural Route Number, City
spi fil		4 Homicide determined	(Opena) Hoopius			Spring G	rove Hospita	Catonsville,MD
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only Certifying Physicia	an: To the best of my knowledgeOn the basis of examination and					
To To	Mec	29b. Signature and title of certifier	and manner stated.		29c. License number		29d. Date signed (A	
		anesz			O.C.M.E.		November 5, 2	
	ŀ	30. Name and address of person who c	ompleted cause of death (Item 2	?3a)				
*		Ana Rubio MD. Assistan	nt Medical Examiner 1	11 Penn Stree	et, Baltimore, MD 212	01		
St Regist	v	31. Date filed (Month, Day, Year)	32. Registar's Signature	K L	W			
Kegist	للثك	MOV O Q	/ LITTLE BUT AND A .	/- /T				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day FREDERICKA DORIS 19, MALISON OCTOBER 2006 3:42 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BRIGHTVIEW ASSISTED LIVING BEL AIR HARFORD 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🕅 F Months Hours Min Director 209-18-2057 81 JULY 24, 1925 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be provided once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MARYLAND HARFORD BEL AIR 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 300 RING FACTORY ROAD 21014 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by Specify: 3 Widowed 4 □ Divorced Specify. WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OFFICE WORKER GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ HIRAM GABLE NESSIE ROSS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1434 GIFFORD CHURCH ROAD ROBERT MALISON (SON) SCHENECTADY, NY 12306 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Bunal 2 ☐ Cremation 3 ☐ Removal from State ST. CYRILS CEMETERY 10/23/06 4 Do vation 5 Dother (Specify) ROTTERDAM, NY 21. Signature of Funeral Service Licenses 22. Name and Address of Facilit BOND FUNERAL HOME 1614 GUILDERLAND AVE., SCHENECTADY, NY 12306 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Arteriosclerotic Heart Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) nding physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☒ No 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown \$ Completed พก Be Certification: To neral Director: /

Division or Vital Records, P.O. Box 68760.

Part II. Other significant conditions o	ontributing to death but not resulting	ng in the underlying	cause given in Part I.	23e. Did tobacco us	se contribute to the cause of death?							
Alzheimers Diseas	se			1 ☐ Yes 2]	No 3 ☐ Probably 4 ☐ Unknow							
				24a. Was an autopsy performed? 1 Yes 2 № No	24b. Were autopsy findings availab prior to completion of cause of death? 1 □ Yes 2 □ No							
25. Was case referred to medical examiner?		26. Place of Death (Check only one)										
1 Yes 2N No	Hospital: 1 ☐ Inpatient 2 ☐ ER	/Outpatient 3 □ D	lome 5 ☐ Residence 6	□Other (Specify)								
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Bb. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	occurred /							
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At home building, etc. (Specify)	e, farm, street, facto	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,								
29a. Certifier 1 ☑ Certifying Ph (Check only one)	ysician: To the best of my knowle niner: On the basis of examination and manner stated.	dge, death occurred and/or investigation	d at the time, date and place n, in my opinion, death occu	e, and due to the cause(s) urred at the time, date and	and manner as stated. place, and due to the cause(s)							
29b. Signature and title of certifier	e Mesuix	hig 29	9c. License number 0 36 24 kg	29d. Date	e signed (Month, Day, Year)							
30. Name and address of person who M	completed cause of death (Item 23	Ba) (Type, Print)	0 2100	00								
31. Date filed (Month, Day, Year)	32. gistrar's Signature											
NOV 0 9 20	106 Steener St	Antile	,									

within 24 hours a To the Funeral [

Medical

State Registrar

6-08425 Edward J. Martell	Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar 1- For State Registrar Reg. No.						6 35421
Physician/ Medical Examiner	Decedent's Name (First, Middle,Last)	J.	MART	EL	Date of Death Month Da November 6,	y Year 2006	3. Time of Death 1117 hrs
	Facility Name (if not institution, give street and number) 201 West Ostend Street			4b. City, Town, or Location of Death Baltimore	1	4c. County of Deat N/A	h

Physici Medical Exami	an/	Registrar 1. Decedent's Name (First, Middle,Last)	EDWARD 3	J. MA	RTEL		2. Date of Month	n Dav Year	3. Time of Death
Total Exami		4a. Facility Name (if not institution, give st			4b. City,	Town, or Locati		mber 6, 2006 4c. County of De	eath
		201 West Ostend Street 5. Social Security Number	7 0-2/10	use lost highe	Baltin		Inder 24Hrs. 8. Date	N/A of Birth (MM/DD/YYYY) 9.	Birthplace (State or
Funeral Director		212-44-9147 ₁ XX _M		yrs. last birthd	Yrs. Month	_		-15-1946	reign MARYLAND Country)
any		Usual Residence of Decedent 10a State 10b. County	10c.	City, Town or				.,	10d. Inside City Limits
faryland 28a-f show 1 at once.	JO.	MD. N/A				BALTIMO	ORE CITY		XX Yes 2 No
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 10 EAST LEE S	TREET		10f. Zip	21201		10g. Citizen of What C	
th with ems 23 t be no	eral	1 Nover Married 2 Married	2. Was Decedent Ever Armed Forces?	r in U.S. 1			Origin? (Specify Yes can, Puerto Rican, et		nerican Indian, Black,
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygeren 2 ar is marked other than "natural", or items 23a or 28a-f She mustic event, the Medical Examiner must be notified at once	by Fun	3 Widowed 4 XX Divorced If Y	Yes 2 2 Yes, Give Year 1968 – Dates:	1971	1 Yes 2			Specify:	WHITE
72 hours "natur al Exam	Completed	15. Decedent's Education (Specify only hard) Elementary/Secondary (0-12)	College (1-4 or 5+)	ed) 16a De du	ring most of wo	rking life. DO N	ive kind of work done IOT use retired)		·
0036 within 72 iene er than '	mple	5	PLUS		INSURA		ROKER	SELF EMP	LOYED
imore, MD 21215-0036 Pages I and 2 should be filed within 72 ment of Health and Mental Hygiens fant: If item 27 is marked other than or other traumatic event, the Medical or other traumatic event,	Be	17. Father's Name (First, Middle, Last) JOSEPH FRANCIS		, 25-27	- CO- 155500		CATHERINE		
MD 2' 12 should th and M 127 is ma umatic e	To	19a. Informant's Name/Relationship (Type E. PATRICK HUGHES (EP.) 9	Mailing Address 07 ROLA	S (Street and I NDVUE R	Number or Rural Roul OAD , TOWSON		21204
Baltimore, MD permit Pages I and 2 she Department of Health and Important: If item 27 is injury or other traumati		20a. Method of Disposition 1 Burial 2 XX Cremation 3		cremators	Disposition (Nar y or other place	1		20c. Location - City	
Baltimo permit Page Department of Important:		4 Donation 5 Other Specify 21. Signature of Funeral Service Licensee		HILLIU		Address of Fa	. 11-08-20	and the second of the second o	MARYLAND,21204 YORK ROAD
Balti permit Departm Imports		R. A. Lun	R. G. RUTH		RUCK T	OWSON F	UNERAL HON	ME,INC. TOWS	SON, MD. 21204
Physician /Medical		23a. Part I. Enter the disease, or complica failure. List only one cause on each	line.	death. Do not e	enter the mode	of dying, such a	as cardiac or respirato	ory arrest, shock, or heart	Approximate Interval Between Onset and Death
xaminer			nging to (or as a conseque	nce of):					Dealin
	ī.	Sequentially list conditions, if any, leading to immediate Due	e to (or as a conseque	nce of):					-
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	e to (or as a conseque						
und transit		events resulting in death) Last Due							
760, cate be execut physician and the burial - tra	edica	Editor Control			, 11/27/C	6 TT			
68760, certificate be ding physicise as the buria	cian/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	2	Fetal death	3 Ect	topic pregnancy	23d. Date of deli	very Day Year
	Physici	1 Yes 2 No 9 Unknown	Pregnant at time Unknown	of death 5	Other (Spe	cify)		-	
, P.O. Box 687 rres that the death certifi signed by the attending be detached for use as t	by Ph	Part II. Other significant conditions co	ntributing to death but	not resulting i	n the underlying	g cause given ır	n Part I. 23e.	Did tobacco use contribute	
ords, P. w requires the seen signer should be dishould			 .			 		Yes 2 ✓ No 3 F Was an 24b. Were	a autopsy findings available
e law re e has be	Completed							performed? death	
tal Rec cian: The l certificate l	O U	25. Was case referred to medical				26 Place of De	ath (Check only one)	Yes 2 No 1	165 2 140
Vita hysicia this ce	To B	1 Yes 2 No	oital: 1 Inpatient			Other	Tructaing Home		ther: Scene
ion of Vending Physeath		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year) FOUND:	FOUN	ID:	28c Injury at W	Subject	scribe how injury occurred thanged self	
W = 0 p P	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	Nov 6, 2006 28e. Place of Injury			, office building	or To	ation (Street and Number or own, State)	
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b		4 Homicide	(Specify) Vacan To the best of my kno		n occurred at the	e time, date and		st Ostend Street, Baltime e cause(s) and manner as s	
To the Hos within 24 h To the Fun completely	Medical	one) Medical Examiner: Or						e, date and place, and due to	
F 2 F 5	ž	29b. Signature and title of ceglifier			29	c. License num O.C.M.E.	ber	29d. Date signed (
		30 Name and address of person who com	poleted cause of death	(Item 23a)		O.O.IVI.E		140Vehiber 7, 2	
LOY		Laron Locke MD. Assistar	t Medical Exami	ner 111	Penn Street	, Baltimore	, MD 21201		
S	tate	31. Date filed (Month, Day, Year)	32. Registrar's S	ignature	South				

			1 - For State Registrar	State of	f Maryla	ind / Depa <i>Ce</i>	artment of I <i>rtificate of</i>	Health ar <i>Death</i>	nd Mental Hy	giene2 Reg. No.	006	35421
	Physici	an	1. Decedent's Name (First, Midd	-					2. Date of D Month	eath Day	Year	3. Time of Death
	/Media	cal	Mary Lou Mara		-61		45 O'S T.		11	4	2006	5:10 A M
	Examir	ier	4a. Facility Name (If not instituti NORTH ARUNDEL	-		B	4b. City, Town,		Death		ounty of Death	\ET
	Funeral		5. Social Security Number	6. Sex		s. last birthday)	If Under 1 Year	If Under 24		rth		lace (State or Foreign try)
	Director		212-28-4654	1□M 2ÅF	75	Yrs.	Months Days	Hours	Min. 12/12/	1930	MARYI	ÄND
	land		Usual Residence of Decedent 10a. State 10b. Count	ty	10c. (City, Town or Lo	ecation				10	0d. Inside City Limits
	a Mary	tor	MD ANNE	ARUNDEL	GL	EN BURN	IE					1 □ Yes 2 □No
	ith the	Olre	10e. Street and Number				10f. Zip Code			10g. Citize	n of What Count	try?
	a 23a	eral	7466 FURNACE B			44.0	21060				S.A.	- 1-1 to 10
5-0036	hours after death with the Maryland tural', or Itema 23s or 28s-f show al Examinar must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Ma 3 □ Widowed 4 □ Divorce		rces? 24 No e		Was Decedent of I f Yes, specify Cub 1 ☐ Yes XXNo		n? (Specify Yes or N Puerto Rican, etc.)		. Race - America Black, White, e pec <i>ify:</i> WHI	etc.
ည		eted	15. Decede (Specify only high	ent's Education est grade completed)		16a. Dece	dent's Usual Dccu kind of work done	pation during most of	f working	16b. Kind	of Business/Ind	ustry
7	within 72 ene. than "na!	Completed	Elementary/Secondary (0-12)		-4or 5+)		kind of work done DO NOT use retire ING CLERI			CITIA INT	OMADN	
א מ	Hygi ther int,	Be Co	17. Father's Name (First, Middle	o, Last)		DIDE	ING CLER		Name (First, Middle		ONARY	
/lan	uld be Mental urked o	ToB	JOHN SMOOT					GAY R	EEDER			
Mary	2 should and Mile mart		19a. Informant's Name/Relation			"			or Rural Route Numb	-		Code)
d)	s 1 and f Health item 27 othar tr		MRS. PEGGY SCHA	AFER/ DAUGH		Place of Dispo	JOYCE DR	IVE, GL	EN BURNIE		1061 tion - City or Tov	- Chata
פֿב	ages ant of it: If it		1 Burial 2 Ocremation 4 Donation 5 DOther (3 Removal from S	Jiaio		sition (Name of natory or other pla KE CREMA)	1			•	
Saltimo	permit. Pages 1 Department of H Important: If its any injury or ot once		21. Signatur on ra Service		- 01				1/6/2006 SINGLETOR		ENSVILL	
ă —	80E 10		W/C	ele mou		1	SECOND A	AVE. S.	W., GLEN 1	BURNIE	, MD 21	061
			a. Pa v. Enter the disease, of shuck, or heart failure. Lis	or complications that ca st only one cause on ea	aused the de ach line.	ath. Do not ent	er the mode of dyi	ng, such as ca	rdiac or respiratory a	rrest,		Approximate Interval Between Onset and Death
,	Pnysician /Medical	4	Imm diate Cause (Final distase or condition resulting in death)	a. Me	tast		Brain					
	Examiner			Due to (d	or as a conse	equence of):						Munth Oyears.
		ner	Sequentially list conditions, if any, loading to immediate cause. Enter Underlying	b. Due to (or as a sonse							T
	ecuted and transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c								
Š,	ificate be executed physician and as the burial-transit		,	000000	or as a conse	equence or);						
09/90		edical		d								
. Box	w requires that the death certif been signed by the attending should be detached for use a	/siclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown		nth 2 ∏Fe ant at time of	tal death 3	Ectopic pregnanc Other (specify)	у		230	Date of deliver	y Day Year
ŗ.	The law requires that the ste has been signed by the page 2 should be detached.	by Phys	Part II. Other significant condit	ions contributing to de	ath but not re	esulting in the u	nderlying cause giv	ven in Part I.	23e. Did t	obacco use	contribute to the	cause of death?
cords	quires an sign uld be								100	Yes 2□N	lo 3□Proba	bly 4 □Unknown
် သ	law re as be	Completed							24a. Was	an 2	4b. Were autop	sy findings available interior of cause of
	: The cete h	Соп							perfo	rmed?	death?	No
Ž	sician certifi rector	Be	25. Was case referred to medical examiner?	Hospitali			. 20 pg. Ott		Death (Check only o			
5	a Physer this eral di	<u>ان</u>	1 ☐ Yes 2 No 27. Manner of Death	28a. Date o	f Injury	☐ ER/Outpatien 28b. Time of	28c. Injur	4 D Nursir	ng Home 5 Resi			
5	ath.	atlo	1 Natural 5 ☐ Pendi 2 ☐ Accident invest	ing (Month tigation	, Day Year)	Injury		k? Yes 2 □ No		. ,		
DIVISION	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 to	Certification:	3 Suicide 6 Could 4 Homicide determ	mined 288. Place	of Injury - At g, etc. <i>(Spe</i> c	home, farm, stre city)	eet, factory, office		28f. Location (City or To	Street and N vn, State)	umber or Rural	Route Number,
	the Hosp nin 24 hou the Fune npletely fil	fedical	one)	ng Physician: To the I I Examiner: On the ba- and mann	sis of examir	nowledge, death nation and/or inv	estigation, in my o	pinion, death o	lace, and due to the occurred at the time,	date and pla	ice, and due to t	the cause(s)
	vit To To	Σ	29b. Signature and title of certific	er 入 入。		UD	29c. Licens			29d. Date si	igned (Month, D.	ay, Year)
		-	30. Name and address of person	who completed cause	of death (Ite	am 23a) (Type	2-1-4)	1743		"10	Plop	
	(υ		L. S EENIVASA 31. Date filed (Month, Day, Year	N, MD 30	0 1. S	HANOV	ERST,	BALT	Imore,	MP,	212	125
	Sta Registra			2006	gional o oigi	F Spa	de!					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35422 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2006 Month Miller Miller November 15:42 William Henry 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Baltimore Washington Medical Center Glen Burnie If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth June 4, 1921 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Days 1**X** M 2□ F 85 MD 213-12-3549 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 X No Anne Arundel Glen Burnie MD 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 21061 U.S.A. 16 Birch Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Scales and Weights Weigher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Henry Miller Sr. Julia Lang 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 16 Birch Avenue Glen Burnie MD 21061 Mrs. Kathryn Miller /Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Nov. 1 Burial 2 □ Cremation 3 □ Removal from State Glen Haven Mem. Park 2006 Glen Burnie, MD 22. Name and Address of Facility Singleton Funeral Home, P.A. 101411 1 Second AVenue SW Glen Burnie MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

3a or 28a-f show t be notified at

or items 23a caminer must be

the Medical

permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygient Important: If item 27 is marked other the any Injury or other traumatic event, the i once.

Director

Funeral

þ

Completed

Be

filed within 72 hours after death with the Maryland

physician and s the burial-trans

The law requires that the death certificate be executed

To the Hospital or Attending Physician: within 24 hours after death.

Division or Vital Records, P.O. Box 68760.

Examine Physician/Medical 2 Completed Be Certification: To To the Funeral Director Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. if yes, outcome pf pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 Ectopic	c pregnancy (specify)		23d. Date of delivery Month Day Year		
Part II. Other significant conditions	contributing to death but not re-	sulting in the underlying	g cause given in Part I.	23e. Did toba	cco use contribute to the cause of death?		
Hyperteryion				1 ☐ Yes	2 No 3 Probably 4 Unknown		
Demeter				24a. Was an autopsy performe			
25. Was case referred to medical			26. Place of De	eath (Check only one)			
examiner? 1 ☐ Yes 2 ဩ No	Hospital: 1 ☐ Inpatient 2 ☐	∡ER/Outpatient 3□	DOA Other: 4 Nursing	Home 5 ☐ Residen	ce 6 ☐Other (Specify)		
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigati	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred		
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ify)	tory, office	28f. Location (Stree City or Town,	et and Number or Rural Route Number, State)		
	Physician: To the best of my kn aminer: On the basis of examin and manner stated.				se(s) and manner as stated. e and place, and due to the cause(s)		
29b. Signature and title of certifies			29c. License number	290	29d. Date signed (Month, Day, Year)		
1 March	an fine		A-40521	1	November 6, 2006		

HOSPITAL DRIVE

GLEN BURNIE, MA 21061

November 6, 2006

State Registrar

10

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 25

32. Registrar's Signature

DR. OCHANEJ

NOV

0 9

2006

31. Date filed (Month, Day, Year)

State Registrar FOWARD

LI,

NOV 0 9 2006

31. Date filed (Month, Day, Year)

Baltimore, Mo

28. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Greene St.

Registrar's Signature

225.

State of Maryland / Department of Health and Mental Hygiene 2006 35424 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death **Physician** Joseph O. Miller 10 10 AM 7,2006 loven ber /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death 707 Maiden Choice Lane #8212 Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 107M 2□ F Vrs 92 Director 220-01-3105 March 12,1914 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County worke r than "natural, or iteme 23e or 28e-f ehor the Medical Examiner must be notified at 1 Yes 2X No Maryland Baltimore Catonsville Direct 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 707 Maiden Choice Lane #8212 21228 USA by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. filed within 72 hours after 1 TYPs 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Insurance Salesman Insurance . Pages 1 and 2 should be filed v thent of Health and Mental Hygie tant: if Item 27 is marked other tally or other treumstic event, it other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Agnes O'Neill Joseph O. Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Scott Miller Son 9405 Parsley Drive; Ellicott City, Maryland 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: if any injury or once. 4 □Donation 5 ☑Other (Specify)Entombment Crest Lawn Mem. Garden 11/10/06 Marriottsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of FacilitSterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville Wece MD 21228 Approximate Interval Between Onset and Death Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) M41.gwmf
Due to (or as a consequence of): Anhytuni 4 **Physician** selder /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physicien and is the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical as IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 □ Fetal death 3 Ectopic pregnancy Day in the past 12 months? ō Month Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a P.0 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown should b 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No s certificete her 1 ☐ Yes 2 No or Attending Physician: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DDA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No ٩ After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: / completely filled in by the f 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examines: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated. within 2 ŝ 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif 29c License number 1)22866 November 8, 2006 Lotte March Pty (Slanton, Mr 21544) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 220 200 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar NOV n 9 2006

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible ink Fraure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens 35425 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** NOVEMBER ROZA **MOSTKOVA** 2006 10:00 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WESLEY HOUSE BALTIMORE N/A 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days 1 □ M 2 □ F Yrs. 07/20/1930 Director 215-35-2251 76 UKRAINE Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 No MD N/A BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2211 WEST ROGERS AVENUE ROOM A 10 21209 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married ŏ 1 ☐ Yes 2 X No Specify: WHITE δ 3 ₩ Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than College (1-4or 5+) Elementary/Secondary (0-12) **TEACHER** permit. Pages 1 and 2 should be flied v Department of Health and Mental Hygier Important: If Item 21 ie marked other it any injury or other traumatic event, ILA ODG. EDUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be SHMUCKLER LEV **ESTHER** RYBSTEIN 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailin and Greet and Number or Rural Route Number, City or Town, State, Zip Code) 114 WALDON-AVENUE - BALTIMORE, MD 21208 VICTORIA MOSTKOVA / DAUGHTER 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition ARLTNGTON CHIZUK 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 11/08/2006 BALTIMORE, MD AMUNO CONG.
22. Name and Address of Facility 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. Soluto 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARCINOMA COLON **Physician** METASTATIC /Medical Due to (or as a consequence of) Examiner Equentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine burial-transit resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ₹ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ormed? 2 No 1 ☐ Yes 2 ☐ No 1 Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Jo 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification; 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after deat To the Funeral Director: completely filled in by the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicida Detertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

Records, ot or Attending Division

107/2006

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

ROBY

E-

DHMH 17 Rev 1/2001

ORIGINAL

-827

32. Registrar's Signature

29c. License number

D-19425

4NDEN AVE-BALTIMORE MD

11/08/2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 26 per doc 9861 11-0-06 vt
State of Maryland / Department of Health and Mental Hygiene
Amend #19b Per FH g861 11/15/06 JH
Certificate of Death

Reg. No. 35426 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Joseph Francis McCarthy, Jr. November 4, 2006 8:59 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Ctr. Baltimore City N/A If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□ F Director 80 220-12-5454 Jan. 14,1926 New York Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow the Medical Examiner must be notified at Maryland Dundalk 1 ☐ Yes 2 X No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? tems 23a or United States 21224 death 7508 Poplar Avenue Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iter any injury or other traumatic event, the Medical Examinan Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 € Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced WWII White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Baltimore County Police Officer Enforcement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frances C. Hoyt Joseph F. McCarthy, Sr. 2 19a. Informant's Name/Relationship (Type, Print) Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>" 21224</u> Dundalk, Maryland 21222 7508 Poplar Ave. Mrs. Beatrice Rose McCarthy 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 11/8/2006 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician a s the burial-Due to (or as a consequence of): .O. Box 68760. Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1 Yes 2 ₩o : After this certific funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death Check only on Hospital: 1 ☐ Yes 2 ☐ 1No 1 🗌 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending after death.

I Director: Aff М 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide within 24 hours a To the Funeral (Medicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DUO 60 SSS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jan Toppin, M.D. 1576 Merritt Blvd. Suite#14 Dundalk, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 9 2006 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month McCart zB Day **Physician** D 21:21 M Samuel 2006 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Maryland Battimore Baltimore Cit university of If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 13, Social Security Number 7. Age (In yrs. last birthday) Funerai unk Months Days Hours 1 ₹M 2 □ F 53 Director 213-62-3346 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 X Yes 2 □ No Director MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 501 W. Franklin Street 21201 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: white Completed by 3 ☐ Widowed 4 ☒ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) un 16b. Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) unk unk unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) University of Maryland 22 S. Greene Street Baltimore, MD 21201 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5☒Other(Specify) in state 21. Sign at re of Euneral Stryice Licensee Ron IId S. Wade, Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate C use (Final disease or condition resulting in death) Asphyxiation Physician CENTIFICATION APPROVED BY MEDICAL EXAMINER /Medical Due to (or as a consequence of). Examiner Food bolus Sequentially list conditions, if any, leading to infinedrate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-tran Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 Ves 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown disease 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed es 2D Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1★Yes 2□ No Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation
6 Could not be determined

10-28-2006 8:20 P M 1 Tyes 2 No Subject choked on food bolus.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Nursing Home

10-28-2006 8:20 P M 1 Tyes 2 No Subject choked on food bolus.

28f. Location (Street and Number or Rural Route Number, 50 Title of Town, State)

10-28-2006 8:20 P M 1 Tyes 2 No Subject choked on food bolus.

28f. Location (Street and Number or Rural Route Number, 50 Title of Town, State)

10-28-2006 8:20 P M 1 Tyes 2 No Subject choked on food bolus. 8:20 P M 2X Accident investigation 3 ☐ Suicide 4 Homicide 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

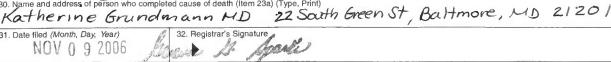
State Registrar

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) NOV 0 9 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



29c. License number

D00054940

29d. Date signed (Month, Day, Year)

10,28,2006

State of Maryland / Department of Health and Mental Hygien 2006 35428 1 - For State Registre Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** Year Sakineh Panahandeh November 5, 2006 10:35 P ^M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death 5809 Plainview Road Montgomery Bethesda If Under 1 Year If Under 24 Hrs. Min. Min. Min. March 21, 1910 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 TSCF 96 Yrs 215-51-7080 Director Iran Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits th and Menta Hygiene. ?7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, Ite Macical Examiner must be notified at 1 Yes 2 No Director MD Montgomery Bethesda 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 5809 Plainview Road 20817 Iran Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White Specify: ð 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fill and Mentat H Be Yahya Panahandeh Omolbanin Panahandeh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is in eny injury or other traum once. Shanla Mokhtari (Daughter) 5809 Plainview Rd. Bethesda, MD 20817 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 St Burial 2 ☐ Cremation 3 ☐ Removal from State National Memorial 11/8/06 Park Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility National Funeral Home 7482 21. Signature of Funeral Service Licenses Diana I Downey Lee Hwy. Falls Church, VA 22042 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** End Stage Dementia years /Medical Due to (or as a consequence of): Examiner Immobility Syndrome Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed ettending physicien and for use as the burial-transit Hypertension vears resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medicai Peripheral Vascular Disease IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No Year Month Day 4☐ Pregnant at time of death 5 Other (specify) P.O. the à signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown **Breast Cancer** Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ◯ No cete hes to certificete Division of Vital 1 Yes 2 🔀 No Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) ၉ 1 ☐ Yes 2 No this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending after death.
Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide in 24 hou.
The Funeral D 1 Cycertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) within 2 î, 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D54749 November 7, 2006 30. Name and address of person who completed cause of death (Jem 23a) (Type, Print) Allen Reilly, MD 801 Toll House Ave. D-1, Frederick, MD 21701 31. Date filed (Month, Day, Year) NOV 0 9 2006 Registrar

-			1 - For State Registrar	State of Mary		artment of F		d Mental Hy	giene 0 0	6 35429
	Physici		1. Decedent's Name (First, Middle, Last) Martha Ann Po	rter				2. Date of De Month	nber ^{Day} 2, 2	3. Time of Death 3:20 P M
	/Medio		4a. Facility Name (II not institution, give s Larkin Chase Hea	itreet and number) 1th Care F	acility	4b. City, Town, o	r Location of De		4c. County o	Death
Sect I	Funeral Director		5. Social Security Number 6. Sex 15	7. Age (II	n yrs. last birthday, Yrs.	If Under 1 Year Months Days	If Under 24 H	fin. 8. Date of Bi		9. Birthplace (State or Foreign Country) III 1001S
	land		Usual Residence of Decedent 10a. State 10b. County		Oc. City, Town or L	ocation				10d. Inside City Limits
	e Mary 3a-f sh	ctor	MD Prince Geo	orges	Bowie					1√ Yes 2 No
	th with th	i Dire	10e. Street and Number 12604 Quarterhors	e Drive		10f. Zip Code 20720			10g. Citizen of Wr United	•
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. By Injury or other traumatic event, the Medical Exammer must be notified at Appear.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Morried	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	r in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No uerto Rican, etc.)	14. Race Black, Specify:	- American Indian, White, etc. Black
2-00	72 hou natura	eted	15. Decedent's Educ (Specify only highest grade	cation	16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	ation during most of	workina	16b. Kind of Bus	
2121	d within giene or then	Completed	Elementary (6-12)	College (1-4or 5+)		DO NOT use retired Nestic Ted		·	Privat	ce Family
Maryland 21215-0036	uid be file Mental Hygarked otheratic event,	To Be C	17. Father's Name (First, Middle, Last) Unknown					Name (First, Middle che Johnse		
Mar	id 2 sho ith and 27 is mu trauma		19a. Informant's Name/Relationship (Ty) Marion A Porter	рө, Print) (Son)		ng Address <i>(Street)</i> Quarterh			•	
ore,	ges 1 ar of Hea if Item or other		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ R		The second secon	osition (Name of matory or other place		Date	20c. Location - C	ity or Town, State
Baltimore,	nit. Pag artment ortant: Injury e		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License		larmony M	em. Park	ss of Facility	/9/06	Landover,	MD
B	Deparation Deparation		23a. Part1. Enter the dispass or compli-	(reel	N.W. Wa	siring con,	ral Home DC 20011
*.	death certificate be executed. Wedical Example and and and and and for use as the burial-transit	dicai Examiner	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1,	Cardiac A Due to (or as a co	onsequence of): On Thrive onsequence of):					Interval Between Onset and Death
.O. Box 6	death certift e attending i id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	3c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date Month	
s, D	The faw requires that the tie has been signed by the bage 2 should be detached.		Part II. Other significant conditions con	tnbuting to death but n	ot resulting in the u	nderlying cause giv	en in Part I.		_	ute to the cause of death?
		Completed by	Old CVA					24a. Was auto perfo 1 Yes	psy prie	ore autopsy findings available or to completion of cause of ath?
Vit.	Physician: this certificanal director, I	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	2 ☐ ER/Outpatie	nt 3 DOA Oth		Death <i>Check only</i> of General General Section 1981		(Space)
ion of	ding After fune		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	28b. Time o	f 28c. Injun Worl			how injury occurred	
Divis	를 를 들	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (S	At home, farm, st Specify)	reet, factory, office		28f. Location (City or To	Street and Number wn, State)	or Rural Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	edical	29a. Certifier (Check only one) Type Tifying Phys	ician: To the best of m lef: On the basis of exa and manner stated	amination and/or in	h occurred at the tin vestigation, in my o	ne, date and pla pinion, death or	ace, and due to the ccurred at the time,	cause(s) and manr date and place, an	er as stated. d due to the cause(s)
	To the within 2 To the complete	Me	29b. Signature and title of certifie			29c. License	number		29d. Date signed (Month, Day, Year)
6	1 70		30. Name and address of person who co	moleted cause of death	(Item 23a) (Tuna	D5702	28		November	7, 2006
1	10		Dr. Aditya Chopra	600 Ri	dgley Ave	enue Suite	e #231	Annapolis	, MD 2140)1
	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 9 2006	32. Registrar's		E				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 0 6 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** James 1erce No Venter 1 11:00 AM 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner If Under 1 Year If Under 24 Hrs.

Months Days Hours Min.

Nov. 24,143 Nursing Home are 5. Social Security Number 6. Sex **Funeral** 9. Birthplace (State or Foreign Country) 1 XM 2□ F 212-34-1476 Director Usual Residence of Decedent 10a. State t0b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is marked other than "natural", or itame 23a or 28a-1 ahow other traumatic event, the Madical Examinar must be notified at 1 Yes 2 No ma by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? (Farden 3652 2120 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Heelth and Mental Hygiene. Int: If itam 27 is marked other then "naturel", or ital 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: ack 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry ited States Elementary/Secondary (0-12) College (1-4or 5+) echnician with 657 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be erce)ames 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pierce Father Balto. Whitney 4023 blen Are 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Scremation 3 Removal from State
4 Donation 5 Other (Specify) Depertment of Important: if any injury or once. motro Crematori 21. Signature of Fiveral Service Licensee 22. Name and Address of Facility 270 Fed Hillon march Rineral Home **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ettending physicien and for use as the burial-transif Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Dementi 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours hours 1 Continuing Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title 9 29d. Date signed (Month, Day, Year) 1113106 30. Name and a diss 838 Grene Tre Rd 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State

Registrar

9 2006

		1- State Amend #1 Per	State of Maryla r Phy G861 I	nd/Dep 1709/06	artmei rtifica	nt of H	lealth a Death		R	eg. No. 🙋	2006	3543
Physici /Medi			Trilby C. Po	teet	26	KE	5		Date of Dea Month	033	2006	
Examir	ner	4a. Facility Name (If not institution, give s 1633 Marley Avenue 5. Social Security Number 6. Sex	7. Age (in yrs	s. last birthday) Yrs.	G1e	n Bu	rnie If Under 2 Hours	4 Hrs. 8	. Date of Birth (Month, Day	Anr Year)	ne Arun 9. Birtl	nde1 hplace (State or Foreig untry)
Director		217-14-9775 Usuel Residence of Decedent 10a. State 10b. County	0.3	City, Town or Lo	ocation				OCt.6,	1923		MD 10d. Inside City Limit 1 □ Yes 2 XN
be filed within 72 hours after death with the Maryland hat Hygiene. Indother then "natural", or Items 23a or 28a-f show event, the Modicel Examinar must be notified at	al Director	MD Anne Arun 10e. Street and Number 1633 Marley Avenue	del G1	en Buri		p Code	0		1	0g. Citize	en of What Co	
ours after dea ral', or items Examiner ma	by Funeral	11, Marital Status 1 Never Married 2 Married 3 WWidowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	ĺ	Was Deci II Yes, sp 1 Yes	**	ispanic Orig in, Mexican, Specify:	in? (Speci Puerto Ri	fy Yes or No- can, etc.)		I. Race - Ame Black, White Specify: Wh	
e filed within 72 ho al Hygiene. I other then "natur vent, the Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	16a. Dece (Give life. Order	kind of w DO NOT	ork done d use retired	during most	of working		16b. Kind	of Business/ Retail	·
should be filed and Mental Hygis marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last) Arthur Brooks 19a. Informant's Name/Relationship (Typ.	ne Print)	19b. Maili	na Addres	s (Street)	Carv	7i11a	First, Middle, Linth: Boute Number	icum	umame) Town, State, 2	Tip Code)
of Health ard I so them 27 is rother trau		Ms. Mary Poteet /D 20a Method of Disposition 11 Burial 2 Cremation 3 Re	aughter 20b.		3 Mar	ley i	Avenue	e Gle	n Burn	ie Ma	aryland	21060
permit. Pages Department of Important: If it eny injury or o		4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	C		2. Name a	nd Addres	ss of Facility	2006 Sing	leton :	Funer	n Burni cal Hom MD 210	ne, P.A.
Physician /Medical Examiner	Iner	23a. Pant 1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if arity, leading to immediate cause. Enter Underlying	Due to (or as a conse	ath. Do not en					espiratory arr		a	Approximate Interval Between Onset and Death Only
rificate be executed ng physician and as the burial-transit	Medical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	equence of):				-	III-	1		70000
that the death certifics led by the attending pt detached for use as t	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	Ectopic Other (s					23	d. Date of deli Month	ivery Day Year
law requires that as been signed b 2 should be deta	þ	Part II. Other significant conditions con	tributing to death but not re	esulting in the u	underlying	cause givi	en in Part I.				e contribute to	the cause of death?
The ete h page	e Completed	25. Was case referred to medical					26 Place	of Doath (24a. Was a autops perform 1 Yes	med? 212 No	24b. Were au prior to death?	itopsy findings availab completion of cause of 2 No
	To B	examiner?	ospital: 1 ☐ Inpatient 2	☐ ER/Outpatie	nt 3 🗆 🗆	OA Oth	05				Other (Spec	cify)
ath. r: After		27. Manner of Death 14 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)			28c. Injun Worl		28	d. Describe h			
To the Hospital or Attendir within 24 hours after death. To the Funeral Director: All completely filled in by the fu	I Certification:	3 Suicide 6 Could not be determined 6 Could not be determined	28e. Place of Injury - At building, etc. (Specialist To the best of my kinds	cify)			no dot- a		City or Tow	n, State)		ural Route Number,
n 24 ho	edical	(Check only 2 Medical Examir	ician: To the best of my kiner: On the basis of examinant and manner stated.	nation and/or in	vestigatio	n, in my o	pinion, death	h occurred	at the time, o	ause(s) a late and p	na manner as lace, and due	to the cause(s)
To th within To th	Me	29b. Signature and title of contifier	Hentu	m		c. License) -	214	38	N	signed (Monti	06 2006
10		MICHPELL, La	Is ed cause of death (It	7 44	Priori) E	FEI	USE 1	116+	TWAY	An	NAPOL	-13 MD2147
St Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	100 a							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 35432 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Price 10:45P M Pauline November 4, 2006 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Towson Multi-Medical Ctr. 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 1 ☐ M 2 🖫 F Yrs. North Carolina Dec. 4,1911 Director 226-09-1079 94 Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a State 10b. County 28a-f ehow Pages 1 and 2 should be filed within 72 hours after death with the Marylannent of Health and Mantal Hygiene.
The state of the state of 1 ☐ Yes 2 XNo Lutherville Maryland Baltimore Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 8502 Marburg Manor Drive 21093 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ⊠ Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Clothing Industry 2 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maggie Scearce Thomas Walker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) Lutherville, MD 21093 Debra Hollenshade (Granddaughter) 8502 Marburg Manor Dr. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State injury or Department of Important: If eny injury or once. 4 ☐ Donation / 5 ☐ Other (Specify) Mountain View Cemetery 11/7/2006 21. Signatur Juneral Service Licensee permit. 22. Name and Address of Facility 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
Table Wise Ave Dundalk, Maryland 21222 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) **Physician** MONTHS END STAGE DEMENTIA /Medical Due to (or as a consequence of): Examiner DAYS FAIL URE
Due to (or as a consequence of): THRIVE Saquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-trans resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No o 9 Unknown 9 Unknown يم 23e. Did tobacco use contribute to the cause of death? Part If, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Onknown should b 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No certificate has tirector, page 2 s 1□ Yes 2□No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No ို this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 27. Manner of Death 28c. Injury at Work? After 5 Pending investigation 1 Naturaf 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide within 24 hours eft To the Funerel DI completely filled in Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29 a. Certifier (Check only one) the tr 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Shrbfe MD DO0 53150 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) SANTIAGO ROAD 9650 21045 SHAKUNMALA GUPTA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

NOV 0 9 2006

William W. Pilkerton 06-07767

Please Type or Print in Black Indelible Ink UNK UNK State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Rea No Registrar 2 Date of Death Physician/ Decedent's Name (First, Middle, Last) Month Day October 16, 2006 1015 hrs **Medical Examiner** William W. Pilkerton 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1531 W. 36th Street Baltimore 8. Date of Birth (MM/DD/YYYY) 9 Birthplace (State or 5 Social Security Numberunk 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs **Funeral** Foreign Months Davs Hours Director Country) Maryland 45 Oct 10, 1961 1 X M 2 Usual Residence of Decedent 10a State unk 10b. County unk 10c. City, Town or Location 19th Rside City Limits unk 1 Yes 2 No show hours after death with the Maryland Director 28a-f s unk 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code unk 23a or 28 notified a USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces White, etc. 1 X Never Married 2 2 X No Yes If Yes. Give Year 3 Widowed Divorced 1 Yes 2 X No specify Specify. White à 15 Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Pages I and 2 should be filed within 72 I Department of Health and Mental Hygiene Important: If item 27 is marked other than " injury or other traumatic event, the Medical E Baltimore, MD 21215-0036 home improvements painter 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Alice Lesheski William Francis Pilkerton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Crystal Pilkerton/sister 636 S. Macon Street Baltimore, MD 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Date crematory or other place) 1 Burial 2 Cremation 3 Removal from State Donation 5 X Other Specify: in state 22 Name and Address of Facility tate Anatomy Board Baltimore, MD 21201 21 Similaring of F neral Service Licen F onald S. Director 655 W. Baltimore Street Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and ailure. List only one cause on each line. /Medical Death Narcotic (heroin, tramadol and hydrocodone) intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examine (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and Physician/Medical X UNPENDED AMENDED#23a,27,28a-f,perME,g861,11/14/06 TT Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Month Day Year 2 past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. ð 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? 2 No ✓ Yes 2 No 1 V Yes 25 Was case referred to medica 26.Place of Death (Check only one) Be examiner? Other4 Hospital. ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other Scene this (Inpatient 2 မ 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred 27 Manner of Death Certification: Natural 1 Yes 2 No 5 Pending 24 hours after death To the Funeral Director: Fnd 10/16/2006 Fnd 10:09 arm unknown 2 Accident Investigation 28e Place of Injury - At home, farm, street, factory, office building, etc 28f Location (Street and Number or Rural Route Number, City 6 X Could not be 3 Suicide or Town, State) 1531 W. 36th Street determined (Specify) found in closet/ storage room Homicide Baltimore, MD 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) October 17, 2006 O.C.M.E. completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001 OCMF 2006

Registrar

NOV 0 9

State of Maryland / Department of Health and Mental Hygiene 35434 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death NOVEMBER 7, 2006 **Physician** 21:00PM John W. Runyeon, /Medical 4a. Fecility Name (If not institution, give street and number)
Saint Joseph Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Center Towson Baltimore B. Date of Birth June 9, 1928 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Months Days Hours Min. Pennsylvania 78 188-20-6612 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene.
Important: if item 27 is marked other then "naturel", or items 23a or 28a-f show enty figury or other traumatic event, the Madical Exandration must be notified at once. 10a State 10b. County 1 ☐ Yes 2 No Director Lutherville Md. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 415 Spring Avenue 21093 USA by Funeral 12. Was Decedent Ever in U.S. Anned Forces? 1. 1 Ves 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. 1 Never Married 2XXMarried Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced WWII White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) CSX Railroad Accountant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Piper Blair Runyeon Ethel ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 415 Spring Avenue Lutherville, Maryland 21093 Mrs. Sandra D. Runyeon/Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State Hilltop Service Corp. 11/9/06 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licen ee 1050 York Road Towson, Maryland 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RESPIRATORY FAILURE **Physician** /Medical Due to (or as a consequence of) **Examiner** RENAL FAILURE Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medicai Examiner The law requires that the death certificate be executed buriai-transit SEPTIC SHOCK and Due to (or as a consequence of): Box 68760, physicien **EMPYEMA** use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 1 ☐ Yes CORONARY ARTERY DISEASE . Were autopsy findings available prior to completion of cause of death? 24a. Was an VALVULAR HEART DISEASE s certificate has b director, page 2 si autopsy 2 No 1□ Yes 2 No 1 Yes After this certific funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. ours after death. neral Director: A tilled in by the fu 6 Could not be 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide 6 within 24 hours a
To the Funeral I
completely tilled Hospitel 12 Cartifying Physician: To the best of my knowledge death command at the time date and place, and due to the nause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a, Certifier To the F 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier and recu let 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RICHARD LINTHICUM, M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 0 9 2006 Registrar

			For State Registrar	State o	f Marylan		artment <i>tificate</i>			and M	ental Hyg	ienez	106	35435
			Decedent's Name (First, Middle	a, Last)							2. Date of Dea	th		3. Time of Death
	Physici		Eleanora	Mav		Ro	hđe				Month Novembe	r 3,20	Year 06	12:46A ^M
	/Medic Examin		4a. Facility Name (If not institution		mber)		4b. City, To	own, or l	Location o		110 V CIMBC		ty of Death	12.40A
	- Adding		1603 Old Bay	Lane			Sev	ern				Ann	e Aru	nde1
	Funeral		5. Social Security Number		7. Age (In yrs.	last birthday)	II Under 1	Year	If Under		8. Date of Birth		9. Birth	place (State or Foreign
ь	Director		216-28-1209	1□M 2X F	74	Yrs.	Months	Days	Hours	Min.	(Month, Day Sept. 2		Coui	MD MD
	P .		Usual Residence of Decedent									,,,,,,,		
	irylar Phow	_	10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	Ba-f	ct	MD Anne A	rundel	G1	en Bur	nie							1 ☐ Yes 2 No
	# 2 M	Dire	10e. Street and Number				10f, Zip C	ode			1	0g. Citizen of	What Cou	ntry?
	23a	Funeral Director	116 Marley Neck	Road			210	060				U.S.A	١.	
2.	i de	Jue	11. Marital Status	Armed Fo	edent Ever in U. rces?		Vas Deceder Yes, specify	nt of His y Cuban	panic Orig	gin? (Spe , Puerto l	cify Yes or No- Rican, etc.)		ce - Americack, White,	
36	s afte	Бу Ft	1 Never Married 2 Marr 3 Widowed 4 Divorced	If Yes, Giv	18		☐ Yes 2		Specify:			Spec	274	ite
8	within 72 hours after death with the Maryland ene. Then "natural", or iteme 23a or 28a-f ehow ha Medical Examinar mual be notified at	d D		Year or Da	ates:									
-5	na na na na na na na na na na na na na n	Completed	15. Decedent (Specify only highes	t grade completed)		(Give	lent's Usual (kind of work OO NOT use	done du	tion <i>tring</i> most	of workii	ng	16b. Kind of I	Business/In	dustry
12	within	ם	Elementary/Secondary (0-12)	College (1	-4or 5+)	Cler		retired)				Motor	Vohic	le Admin.
רא : ק	Hygur Hygur		17. Father's Name (First, Middle,	Last)		OTET		T	18 Mothe	r's Name	(First, Middle, I			Te Admin.
au	o do	Be C	Edward Hutson	,							Simmont	valuon Suma	<i>)</i>	
2	hout d Me mark mark	ဥ	19a. Informant's Name/Relationsl	nin (Type Print)		19h Mailin	n Address (Street ar			Route Number	City or Tour	a State 7in	Codel
Baltimore, Maryland 21215-0036	perniit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelih and Mental Hygiene. Department of Heelih and Mental Hygiene. She there 27 is marked other then "natural; or tieme 27 is marked other then" natural; or tieme 23a or 28a-f ehow any injury or other traumatic event, the Medical Examinar must be notified at 800ct.		Mr. Dennis K. R			1					n, MD 2	,	1, 3tate, 21p	Code)
ď.	Heel Heel Heel Heel	1 3	20a. Method of Disposition	onde, bon	20b. P	Place of Disposemetery, cren					14-19-1	20c. Location	- City or To	own State
ē	nt of nt of t: H it		ty⊡⁄Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)	3 Removal from	State				(L	Nov.	8,			
ᄩ	rtan njunj		21. Signature of Funeral Service		Ma	ryland				200		Crowns		
Ba	Department of the population o		Sulla man	Shink	MIU		. Name and	Addiess	or raciiity	Sin	gleton	Funera	l Hom	e, P.A.
			23a. Part1. Enter the disease, or	complications that co	aused the death						Glen Bu		D 210	61 Approximate
			shock, or heart failure. List Immediate Cause (Final	only one cause on e	ach line.	_	ine mode	or dying,	Sucii as i	Jardiac O	respiratory arre	751,		Interval Between Onset and Death
	hysician /Medical		disease or condition resulting in death)	a	LFI	WI	VG:	TV	70R					12 MONTHS
	Examiner		,	Due to (or as a consequ	uence of):	1	201	(60					
		16	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b Due to (or as a consequ	DNIC	/ (19/4	((0	USE				su yesters.
	B/6/ #	nine	Cause (Disease or injury	(H2 1 0x		1001							
	xecu and al-tra	Examiner	that initiated events resulting in death) Last	c	or as a consequ		ION							13 YEARS-
8760,	Ilcate be executed physicien and the burial-transit	dicai E												
687	phys phys s the	dic		d										
×	attending p	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out								234 D	ate ol delive	
Вох	atter I tor L	ciar	in the past 12 months?		inth 2 ☐ Fetal ant at time of de		Ectopic preg Other (spec						onth	Day Year
o j	Attending Prysicien: The law fequires that the death certific core; the court of th	by Physician/Me	1 ∐ Yes 2 🛣 No 9 🗍 Unknown	9□ Unkno			01101 (9000				1/			
σ.	inat it	y P	Part II. Other significant condition	ns contributing to de	ath but not resu	ulting in the un	derlying cau	se given	in Part I.		23e. Did tob	acco use con	tribute to th	e cause of death?
sp.	ures grad Id be	D D	HYPOTH	120191SM							1 🗆 Ye	s 2 No	3 Prob	ably 4 Unknown
000	shou	lete	الم (الم	7 - 1 7 - 1 -	GALLB	MA	< A	100	Ω.		24a. Was a	245	Mara auto	any findinan available
Division of Vital Records, P.O.	9 hes	Completed		PU OF	CANULA	L/3/1016		VCC	,		autops	y .	prior to cor death?	psy findings available apletion of cause of
e i	in the firm of the party of the	CC	CHO.	ONIC E	17/ Hys	GMA					1 ☐ Yes 2	DE(No		2 No
5	cent	00	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:		50.0	-5.00	Other			Check only on	9)		Son
ō	al d	5	27. Manner of Death		npatient 2 : of Injury h, Day Year)	28b. Time of			4 () 1401		ne 5 Reside	w injury occur	her <i>(Specif</i>) rred	Son Residence
O	th.	ţ	1 Natural 5 ☐ Pending 2 ☐ Accident investig		h, Day Year)	Injury	М	Unjury a Work?	s 2 □ N			,,		
/ISI	Attending of the tune to	fica	3 ☐ Suicide 6 ☐ Could n	ot be 28e. Place	of Injury - At ho	me, larm, stre	et, factory, o	office		2	81. Location (Sti	eet and Num	ber or Rura	/ Route Number.
á	atter 1 Direct	Certification:	4 Homicide	buildir	ng, etc. (Specify)	,				City or Town			
	spita nours ners / tille		29a. Certifier 15 Certifying	g Physician: To the	best of my know	wledge, death	occurred at	the time	, date and	place, a	nd due to the ca	use(s) and m	anner as st	ated.
	24 i	edicai	(Check only 2 Medical E	xaminer: On the ba	isis of examinat	ion and/or inv	estigation, in	my opir	nion, deatl	h occurre	d at the time, da	ite and place,	and due to	the cause(s)
	To the Hospital of Attending Physicien. The law fequires the within 24 hours after death. To the Funeral Director: After this cartificate has been signed completely titled in by the tuneral director, page 2 should be de	Me	29b. Signature and title of certifier	1-				icense i		0	29	d. Date signe	ed (Month, I	Day, Year)
)) l. le	idly !	1.5.		2	-2	z 60°	9		NOVA	1360	6.7001
	17	ŀ	30. Name and address of person v	who completed cause	e of death (Item	23a) (Type, F	Print)			-		,0-70	·)L/-	0 2006
	10		RUBEN A	KIDER 1	1.9. 74	45 F	IRNAC	E1	32an	CH	Ad Gue	N BUR	NIE +	6.2006 1d 21060
	Sta	te	31. Date filed (Month, Day, Year)	32.	egistrar's Signal	ture				- 14		201		2/00
	Registr	ar	NOV 0 9	2006	Cassed S	or An	and a							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #9,15,19te at Maryland, 19 and 120at et bleath and Medial Hypiand /06 Jh 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 17:00 pM metta umse 27, 2006 Yvonne October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE UNIVERSITY OF MARYLAND MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖾 F Months Days Hours 54 3/21/5 220-52-6229 Director Maryland Usual Residence of Deceden filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 1 ☐ Yes 2 No "natural", or items 23a or 28a-f sh edi-al Examiner must be notified MD Harford Director Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 130 hanover Street 21001 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry History 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Harford Center Care Giver unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) -unk Pages 1 and 2 should be nent of Health and Mental Gwendolyn G.Brown Charles H. Williams, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health an University of Maryland Stephine Cadwell 22 S. Greene Street Baltimore MD 139 Hanover St. Abingdon, MD21001 Department of Health Important; if item 27 any injury or other to once. 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 11/06/2006 Baltimore, Md Metro Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility William C. Brown Community F.H. 351 S. Phila. Blvd.Aberdeen, Md 21001 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cau (Final disease or condition resulting in death) Pulmonary E Due to (or as a consequence of): **Physician** Edemo days /Medical Examiner End Stage Reno Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Hypertension
Due to (or as a consequence of): attending physician and for use as the burial-tran Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by tic Stenosis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Ongestive Heart Failure 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performe 201 No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No 1 ☐mpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1-Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) bracy anna 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

MD

Balhmore

Registrar's Signature

Greene

NOV 0 9 2006

31. Date filed (Month, Day, Year)

		ľ	1 - For State Registrar	State of M	aryland /	Department Certificate	of Health and of Death		ene2 UU5 g. No.	3543
	- 6		Decedent's Name (First, Middle, I	Last)				2. Date of Death		3. Time of Death
	Physicia Medic/		Catharine	N	lary	R	aab	November	Day Year 5 2006	3:45 A
	Examin		4a. Facility Name (If not institution, g	give street and number,)	4b. City, T	own, or Location of De	ath	4c. County of Dea	
			Srella Maris N	irsing Home	<u>, </u>	Timo	nium		Baltimor	
	uneral			. Sex 7. A	ge (In yrs. last b		Year If Under 24 H Days Hours Mi	n. (Month, Day,		thplace (State or Foreignuntry)
	irector		215-09-4382 Usual Residence of Decedent	X	98			Sept. 20	1908 Ma	ryland
hours after deeth with the Maryland	Mow I		10a. State 10b. County		10c. City, To	n or Location				10d. Inside City Limit
Mar	ritan "natural", or itema 23a or 28a-f ahow the Medical Examinar must be notified at	cto	Maryland Baltimo	ore	Timon	ium				1 ☐ Yes 2 ☐ N
th th	or 28	Director	10e. Street and Number			10f. Zip (ode	10	g. Citizen of What Co	ountry?
ath w	23a	Ta I	2300 Dulaney Va			210			U.S.	Α.
ar de	t in the	Funeral	11. Marital Status	12. Was Decedent Armed Forces	?	13. Was Decede	nt of Hispanic Origin? y Cuban, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, Whit	
saffe	o d		1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	No	1 ☐ Yes 2	No Specify:		Specify:	
Don	tural BIED	Completed by	15. Decedent's		16	a. Decedent's Usual	Occupation		6b. Kind of Business	hite
in 72	c Si	plet	(Specify only highest	grade completed)		(Give kind of work life. DO NOT use	done during most of w	rorking	DD. KING OF DUSINGSS	moustry
within	- 3	E o	Elementary/Secondary (0-12)	College (1-4or NA		Sales Cle	rk	ס	epartment	Store
9 11 90 1 H	d other avant, II	0	17. Father's Name (First, Middle, La			Dured Ore	7	ame (First, Middle, Ma		DUCTO
and Montal		To B	John		R	aab	Catha	rine		Rebbel
200	tam 27 is marke other traumatic		19a. Informant's Name/Relationship	(Type, Print)	19	b. Mailing Address (Street and Number or I	Rural Route Number, (City or Town, State, .	Zip Code)
di ea	nm 27 i ther tra		Catharine Melody	7 (Neice	1818		rington Rd		ille, Mar	yland 21030
1	if the		20a. Method of Disposition 1 Burial 2 □ Cremation 3	□Removal from State	comet	of Disposition (Name ery, crematory or oth	er place)	Date 20 ember	Oc. Location - City or	Town, State
200	Important: if its any injury or ot once.		4 ☐ Donation 5 ☐ Other (Spe			d Heart o	f Jesus 10	2006 D	undalk, Ma	aryland
Tage of	mpor any in		21. Signature of Funeral Service 1.0) ((deline)	1	22. Name and W . D	Address of Facility abrowski/Cl	hoinacki F	uneral Hor	mes P.A.
10	5 4 9	8	23a. Part 1. Enter the disease, or co	Vonec	fer-	1005	Dundalk Av	e. Baltimo:	re. Maryla	and 21224
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	ly onercause on each i	me. ₄				it,	Interval between
	sician		Immediate Cause (Final disease or condition	/ <u>_</u>	E126	POVISE	ular 1	135632		Onset and Death
	edical miner		resulting in death)	Due to (or as	onsequence	of):	35.3			
		_	Sequentially list conditions,	b						
	sit	ole	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	• Ot):				
	al-trar	Examiner	that initiated events resulting in death) Last	CDue to (or as	a consequence	of):				
	physicien and the burial-transit	a				•				
	phys	edical		d						
	ettending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of de	livery
	d for	Cla	in the past 12 months?	1⊟Live birth 4⊟Pregnant a	2 Fetal deat t time of death	h 3 □Ectopic pre 5 □ Other (spe	gnancy cify)		Month	Day Year
	ed by the detached	hys	9 □ Unknown	9□ Unknown						
	igned be det	by P	Part II. Other significant conditions		out not resulting	in the underlying car	ise given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
	o to							1 🗆 Yes	2 □ No 3 □ Pi	obably 4 Ninknow
	2 shoul	ompleted	RECON	N/ str	dell			24a. Was an	24b. Were au	itopsy findings available
	<u> </u>	E						autopsy performe	ed? death?	completion of cause of
	certificate irector, pag	Se C	25. Was case referred to medical				26. Place of D	eath (Check only one)		LLINO
	S = 0	ToB	examiner?	Hospital: 1 Inpati	ent 2 ER/C	utpatient 3 DOA	1	Home 5 Residen		cify)
r death.	After th funeral		27. Manner of Death SNatural 5 ☐ Pending	28a. Date of Inju	ury 28b.	Time of 28	: Injury at Work?	28d. Describe how		
aath	or: Al	atic	2 ☐ Accident Investigat	ion		М	1 ☐ Yes 2 ☐ No			
ter de	Diractor:	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	286. Place of in	jury - At home, t tc. (Specify)	arm, street, factory,	office	28f. Location (Stre City or Town,	et and Number or Ri State)	ural Route Number,
ILS at	Tel Del									
4 hou	Fune ely fi	edical	(Check only ~2 Medical 2X	Physician: To the best aminer: On the basis of	of examination a	e, death occurred at nd/or investigation, i	the time, date and plan my opinion, death oc	ce, and due to the cau curred at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
hin 2	To the Funeral Director: completely filled in by the	Med	one) 29b. Signature and title of certifier	and manner st	ated.					
W	2 00		250. Signature and the of centre?	Ehred S	mos	7 290.	License number	290	f. Date signed (Mont	
•								,		,-
	/		30. Name and address of person wh	- 000			DOND TIME	ONIUM, MD	21093	
V	Sta		EDDIE NAKHUDA, 31. Date filed (Month, Day, Year)		O DULANI rar's Signature	EY VALLEY	TOAD IIIIC			
	36	11:1	Date [Day, roul/	oe, Dodist	and a congression of					

32. Begistrar's Signature

NOV 0 9 2006

ORIGINAL

DHMH 17 Rev 1/2001

State

Registrar

3:45 A.M.

NOVEMBER 5, 2006

CATHERINE RAAB

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 2006 Margaret Sullivan Nov. 7, 5:30 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Morningside House of Ellicott City Ellicott City Howard 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🖫 F 214-40-5817 68 Director DEC 31, 1937 MD Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f shother traumatic event, the Medical Examiner must be notified in 1 ☐ Yes 2 No MD Howard Director Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5300 Dorsey Hall Dr #318B 21042 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Interest if Item 27 is marked other than "natural", or ite nry or other traumatic event, the Medical Examines nry or other traumatic event, the Medical Examine 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☑ Divorced þ White Be Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Director On Our Own 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William C. Sullivan Mary Burgan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Luke McCusker/son 24 Chapeltowne Cr Nottingham, MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 11/8/06 Baltimore, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licens Todd Dring Cremation Society of Maryland, Inc. rications that caused the death. Do not enter the mole of lying, so has a dia a limit of the mole of lying and as a dia a limit of the mole of lying and as a dia a limit of the mole of lying and as a dia a limit of the mole of lying and as a dia a limit of the mole of lying and as a dia a limit of the mole of lying and as a dia a limit of the mole of lying and a limit of limit o Approximate
Interval Between
Onset and Death 23a. Part1. Enter the disease, or comshock, or heart failure. List on Immediate Cause (Final **Physician** DOXIQ disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) ed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an perform rmed 2 No certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 No Other: 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ဥ 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated within 2 To the 29c. License number 29b. Signature and title of certifie 29d. Date signed, (Month, Day, Year) 2 100 D61731 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9105 Fronklin Sq. Dr, Ste 312 Cardenimo

Registrar DHMH 17 Rev 1/2001

State

Regina 31. Date filed (Month, Day,

State of Maryland / Department of Health and Mental Hygienes Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month 3:14 P M October 21, 2006 Martha Sacramo /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Village Health Care Montgomery Village Montgomery If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) June 12,1917 9. Birthplace (State or Foreign Country) PA 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🖺 F 89 June Director 168-44-1225 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County r 28a-f show notified at 1 ☐ Yes 2 No Director MD Poolesville Montgomery 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code a or "natural", or items 23a 17204 Chiswell Road 20837 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 XNo 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. þ White 3 XWidowed 4 ☐ Divorced al Hygiene. I other than "natura event, the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Clothing O 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anthony Caterino Josephine Motto 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ray Sacramo (Son) 17204 Chiswell Road, Poolesville, MD 20b. Place of Disposition (Name of Connetery crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. 1X Burial 2 ☐ Cremation 3 ☐Removal from State Cemetery 4 □ Donation 5 ☐ Other (Specify) 10-26-06 Yeadon, PA 22. Name and Address of Facility Pennsylvania Burial Company 21. Signature of Funeral Service Licensee 1327 S. Broad St., Philadelphia, PA 19147 Ucca Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Aspiration Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Cancer of Unknown Primary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a consequence of physician and ss the burial-transit requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗓 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 | Yes 2 | No 3 | Probably 4 K Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 X No 1∐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4K Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 🔀 No ဥ 2 ☐ ER/Outpatient 3□ DOA After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation (Month, Day Year) Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) October 21, 2006 D MILET MIS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vinu Ganti, M.D., P.C., 19529 Doctor's Drive, Germantown, MD 20874 31. Date filed (Month, Day, Year) istrar's Signature State

DHMH 17 Rev 1/2001

Registrar

NOV 0 9 2006

			1 - For State of Registrar	Maryland / Dep <i>Ce</i>		lealth and Me Death	ental Hygie Reg.	ne2006	35440
	Physici /Medio Examir	cal	1. Decedent's Name (First, Middle, Last) Amelia Teller Stolwein 4a. Facility Name (If not institution, give street and num Shady Grove Adventist Ho		4b. City, Town, or Rockvil	N r Location of Death		7, 2006 4c. County of De	0040 M
	Funeral Director		•	7. Age (In yrs. last birthday,			3. Date of Birth (Month, Day, Ye OV. 18,		Birthplace (State or Foreign Country) WYORK
	the Maryland 28a-f ehow	rector	10a. State	10c. City, Town or L Rockvill			10g.	Citizen of What	10d. Inside City Limits 1 Yes 2 No X Country?
5-0036	s 1 end 2 should be filed within 72 hours after death with the Maryland f Heelth and Mental Hygiene. Item 27 is marked other than "naturel", or Items 23a or 28a-1 ehow other traumatic avent, the Madical Extension count be notified at	eted by Funeral Director	8 Baltimore Road 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed)	tes:	1 ☐ Yes 2 ☑ No	ation during most of working	ify Yes or No- ican, etc.)	14. Race - Ar Black, W Specify: V	white
Maryland 21215-0036	uld be filed within Mental Hygiene. irked other than " itic avent, the Ma	To Be Completed	Elementary/Secondary (0-12) College (1-5+ 17. Father's Name (First, Middle, Last) Chester Teller	4or 5+) // Nt	DO NOT use retired	18. Mother's Name (Eva Magne	First, Middle, Mai	Hospital den Sumame)	
\geq	DENE	•	19a. Informant's Name/Relationship (Type, Print) Freda Balkan / daughter 20a. Method of Disposition 1 □ Burial 2▼Cremation 3 □ Removal from S	20b. Place of Disp cemetery, cre	704 Seneca losition (Name of lomatory or other place	Da	ourt Gai	thersbur	or Town, State
Baltimore,	permit. Pages 1 em Depertment of Heeli Importent: if item 2 any injury or other anges.		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee From L. Dawk	National		y Nov. 10 ss of FacilityNatio Highway Fa		eral Hom	
760,	Physician // Medical Examiner pepping physician and physician site prival-itransit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	chane. cdial Infarct or as a consequence of):		g, seen as cardiac or			Approximate Interval Between Onset and Death 1 day 1 day
O. Box 68	he death certifica / the attending ph ched for use as th	Physician/Med	in the past 12 months?	int at time of death 5	□Ectopic pregnancy	/		23d. Date of o	delivery Day Year
ords, P.O.	equires that t en signed by buld be deta		Part II. Dther significant conditions contributing to de Renal failure, Hyperkale	ath but not resulting in the mia, Metabol	underlying cause giv Lic Acidos	en in Part I. 31S			o to the cause of death? Probably 4 Unknown
of Vital Records,	an: The taw r lificete has be or, page 2 sh	e Completed by	25. Was case referred to medical			26. Place of Death (24a. Was an autopsy performed 1 Yes 2.	prior i	autopsy findings available to completion of cause of ?? (es 2 No
Division of Vi	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effer death. To the Funeral Diractor: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification; To Be	27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined.	patient 2 ER/Outpatier f Injury 28b. Time of Injury - At home, farm, st g, etc. (Specify)	of 28c. Injur Wor M 1	er: 4 Nursing Home y at 28 k? Yes 2 No	e 5 Residenc	injury occurred	pecify) Rural Route Number,
	Hospital 124 hours e Funeral C letely filled	Medical Ce	29a. Certifier 1{ X Certifying Physician : To the (Check only one) 2 ☐ Madical Examiner : On the band mann	sis of examination and/or in					
	To th withir To th comp	Me	29b. Signature and title of certifier	Pal.	29c. Licens 6440			Date signed (Moreover 7	
	Sta	ate.	30. Name and address of person who completed cause Rebecca Barker, M.D. 9901 31. Date filed (Month, Day, Year) 32. Re	. Medical Cer	nter Drive	e Rockville	e, MD 208	850	
34	Regist		NOV 0 9 2006	istrar's Signature	Service .				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] [] [For Stete Registre Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Joseph M. Shipley, Jr. 855 Nov 5, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore 4560 Finney Avenue If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Months Days 1 □XM 2 □ F 218-58-7678 Aug 29, 1952 Maryland 54 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 X Yes 2 □ No Baltimore Director Maryland N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 4560 Finney Avenue 21215 Be Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 🙀 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🖫 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Kennedy Krieger Janitor 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Hilda Littlejohn Joseph M. Shipley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 607 Pennsylvania Avenue Baltimore, Maryland 21217 Eileen Hill Aunt 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ☐ Burial 2 XCremation 3 ☐ Removal from State 11/08/06 Catonsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Estep Brothers Funeral Service, P. A 1300 Eutaw Place Baltimore, Md 21217 the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Cardvac Immediate Cause (Final disease or condition

Physician /Medical Examiner

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

o the Hospitei

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other traumatic event page.

Funeral

Director

or 28e-f show

items 23a

0

filed within 72 hours efter death

other traumatic event, the Mudical Exercical must be notified at

Medical Certification: To Be Completed by Physician/Medical Examiner ours efter death.

ners! Director: A
filled in by the fu within 24 hours e To the Funersi (completely filled

2006

32. Registrar's Signature

31. Date filed (Month, Day, Year)

resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):	androwyigaly & y.
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)	23d. Date of delivery Month Day Year
Part II. Other significant conditions of	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
		24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hom	
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		28f. Location (<i>Street and Number or Rural Route Number</i> , City or Town, State)
	nysician: To the best of my knowledge, death occurred at the time, date and place, a niner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.	
29b. Signature and title of certifier	22. License number DO0/8/44	29d. Date signed (Month, Day, Year)
30. Name and address of person who Romarco BAC	completed cause of death (Item 23a) (Type, Print) THE LAST STRAN HOSE FULL, Bal	fr. MD 21215

Registrar DHMH 17 Rev 1/2001

State

12

Please Type or Print in Black Indelible Ink

sap Suk Sun		Sta 1- For State Registrar	ate of Maryland		ment of I ficate of L		Mental H	, ,	eg No. 200	6 3544
Physicia Medical Examin	n/	Decedent's Name (First, Middle	GAP SU	K SUH				2. Date of Dea Month Novembe	th	3. Time of Death 1208 hrs
para .		4a. Facility Name (if not institution	, give street and number)			. City, Town, or Loc	cation of Death		4c. County of Dea	th
Funeral	a à	University of Maryland 5. Social Security Number		e (In yrs. last		Baltimore If Under 1 Year	If Under 24Hrs	s. 8. Date of Bir	N/A	
Director			XX M 2 F	59	Yrs.	Months Days	Hours Mir	_		
any		Usual Residence of Decedent 10a State 10b. County	-	10c. City, To	wn or Location	1				10d. Inside City Limits
Maryland 28a-f show any d at once.	tor		GOMERY				RING			1 Yes 2 XXNo
the Mar a or 28a tified at	Director	10e. Street and Number 405 HILTONHEAD	COURT			10f. Zip Code 20905		11	0g. Citizen of What Co	
death with the Maryland or items 23a or 28a-f shomust be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Mar	12. Was Decedent Armed Forces?			Decedent of Hispar , specify Cuban, Me				rican Indian, Black,
after des al", or i	by Fu	3 Widowed XX Divo	rced If Yes, Give Year 19		0 1 Y	es XX No s	pecify:	,		OREAN
2 hours "natur	ited k	15. Decedent's Education (Speci Elementary/Secondary (0-12)	fy only highest grade com College (1-4 or 5		a. Decedent's during mos	Usual Occupation tof working life. DC	(Give kind of v NOT use ret	work done red)	16b. Kind of Business	/Industry
0036 within 7 jene. rer than	Completed	11 YEARS			AIR	CONDITIO				DITION CO.
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	17. Father's Name (First, Middle, L		MOON S	SUH	18.1		(First, Middle, NON YE	Maiden Surname)	
MD 21 d 2 should lth and Me n 27 is ma aumatic ev	의	19a. Informant's Name/Relationshi JAMES WAN SUH	(BROTHER)		19b. Mailing A	ddress (Street an	COLIRT	Rural Route Num	SPRING MAD	e, Zip Code) YLAND, 20905
	ŀ	20a. Method of Disposition 1 Burial 2XX Cremation		. cren	e of Disposition	on (Name of cemete	эгу,	Date	20c. Location - City o	r Town, State
Baltimore, permit Pages I an Department of He Important: If ite injury or other tr		4 Donation 5 Other Spe 21. Signature of Funeral Service L	ecify:	"" HILL1	ΓOP SER	VICE COR	•)7-2006 ———		RYLAND,21204
	ž	R. H. Rutts	(R. G.RU	-	RUC	K TOWSON	FUNERA		INC. TOWS	YORK ROAD ON,MD.21204
Physician /Medical		23a. Part I. Enter the disease, or c failure. List only one cause o	omplications that caused n each line. a Stab Wound to (not enter the	mode of dying, suc	h as cardiac o	r respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
≒xaminer		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conse							Death
74.00	<u>le</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b. Due to (or as a conse	quence of):						
€ 9 ±8	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of):	_					5)
execu	Medical	UNPENDED	dAMENDED							
68760, certificate be anding physici		F FEMALE: 3b. Was decedent pregnant in the	23c. If yes, outcom	ne of pregnance		2 75			23d. Date of deliver	
Box 687(ne death certifica the attending pl	Physician/	past 12 months? 1 Yes 2 No 9 Unkn	4 Pregnant at	time of death		death 3 E	Ectopic pregna	псу	Month	Day Year
	Z S	Part II. Other significant conditio	ns contributing to death	but not result	ting in the und	erlying cause giver	n in Part I.	23e. Did tol	bacco use contribute to	the cause of death?
ords, P.C	ted by							1 Yes	2 No 3 Pro	
Record The law re cate has be	Completed						<u> </u>	autops perfori	sy prior to med? death?	utopsy findings available completion of cause of
Vital Recysician: The his certificate director, page	Be C	25. Was case referred to medical examiner?					Death (Check o	1 Yes 2 only one)	2 No 1 Y	es 2 No
Ing Physic After this	의	1 Yes 2 No 27. Manner of Death	28a. Date of Injur	v 28t	Outpatient 3				Residence 6 Othe	r.
Division of Vital Records, tal or Attending Physician: The law requints after cleath al Director: After this certificate has been side in by the funeral director, page 2 should the funeral director, page 2 should the funeral director.	ation	1 Natural 5 Pendir 2 Accident Investig	gation		40 hrs		2 V NO	Subject stab		
Divis pital or At ours after d neral Direct filled in by	Certification:	3 Suicide 6 Could determ	not be		, farm, street, f	actory, office buildi	-	or Town, St	treet and Number or Ru ate) Vest Mulberry Street	aral Route Number, City Baltimore MD
0 - = >	- 1	29a. Certifier 1 Certifying Phy	sician: To the best of my iner:On the basis of exam	knowledge, o	death occurred	at the time, date a	nd place, and	due to the cause	e(s) and manner as star	ted.
To t To t Com	Medical	29b. Signature and title of certifier	and manner stated.	Illiation and/o	- Itivestigation	29c License nu		t the time, date a	29d Date signed (Mo	
		4/	M. 1E			O.C.M.E	İ.		November 4, 20	06
WX,		3C. Name and address of person w Jack Titus MD. Depu			•	Street, Baltimo	ore, MD 21	201		
Star Registra	te ar	81. Date filed (Month, Day, Year)	2006 32 Registrar	s Signature	A 5004	Sec. 9				
	_									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 10a, b, c, e, f per fh 8861 11-28-06 vt State of Maryland? Department of Health and Mental Hygiene 0 0 5 35443 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Elsie M. Scibek 1:34A M November 5,2006 /Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 205 9th Avenue SE Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Davs Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 ☐ M 2 🗓 F 82 Months Director 154-16-3009 Nov.15,1923 NJ Usual Residence of Decedent the Maryland ?7 is marked other than "natural", or Items 23a or 28a-f ahow traumatic avant. It e Madical Examinar must be notified at 10c. City, Town or Location 10d. Inside City Limits Middle Sex Parlin Directo Anne Arundel 1 Yes 2 X No Glen Burnie 10e. Street and Number 33 Roosevelt Blv. 10f. Zip Code 10g. Citizen of What Country? 205 9th Avenue SE 21061 08859 U.S.A. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natu any injury or other traumatic avant. If a Mental once. 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Custodian School System 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Michael Horvath ပ Rose Nagy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Sharon Scibek/Daughter 205 9th Avenue SE Glen Burnie MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Nov. 9. 4 ☐ Donation 5 ☐ Other (Specify) St. Stanislaus Cem. 2006 Sayersville, New Jersey 21. Signature of u eral Service Licensee 22. Name and Address of Facility Singleton Funeral Home, P.A. Chil 1 Second Avenue SW GLen Burnie MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CORONARY ARTERY DISEASE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year P.O. F 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, CONGESTIVE HEART FAILURE 1 ☐ Yes 2 ☐ KNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? SEVERE ADRTIL 24a. Was an page 2 autopsy performed certificate 1 Yes 2 X No 1 ☐ Yes 2 ☐ No or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 KResidence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA s after death.

I Director; After this of in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Hospital filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 157531 m NOVEMBER 06, 2006 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Veterans Mesy 8601 mobit Negi

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day Year)

NOV 0 9 2006

Sports

32. Registrar's Signature

Suite 204 Millorsolle MD 21138

06-08392 John Sunoski Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Month Day November 5, 2006 **Medical Examiner** Sumoski 1312 hrs 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deat 3809 Fairhaven Avenue Apt. 3 N/A Baltimore City 5 Social Security Number **Funeral** 7 Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8 Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Germany Days Hours Director 220-68-5445 49 08/22/1957 1 V M 2 Usual Residence of Decedent J. 10c. City, Town or Location 10d Inside City Limits 28a-f show 1 X Yes 2 No Baltimore Maryland N/A Director 10e. Street and Number 10f. Zip Code 10g Citizen of What Country notified at 21226 USA 3809 Fairhaven Avenue, Apt#3 23a Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, Black, must be or items Armed Forces? White, etc. 1 Never Married Married Yes 2 X No X Divorced Widowed If Yes, Give Year 1 Yes 2 X No specify: Specify: White ğ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Pages I and 2 should be filed within 72 h tent of Health and Mental Hygiene unt: If item 27 is marked other than "n ir other traumatic event, the Medical E. Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Cook Restaurant 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be Anthony J. Sumoski Ursula Brozist 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 47 Rol Park, Millersville, MD 21108 19a. Informant's Name/Relationship (Type, Print) 2 Anthony J. Sumoski (father) 20a Method of Disposition 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State JULY.

July or of P.

Important: 16 crematory or other place) Nov. 07 1 Burial 2 X Cremation 3 Removal from State Metro Crematory Inc. Baltimore, Maryland Donation 5 Other Specify 2006 21. Signature of Funeral Service Ligenses 22. Name and Address of Facility Stallings Funeral Home, P.A. <u>3111 Mountain Road.</u> Pasadena. 23a Part I Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, **Physician** Approximate Interval failure. List only one cause on each line. Between Onset and /Medical Complications of chronic alcohol abuse Death Immediate Cause (Final disease Sxaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d. and tran Physician/Medical X UNPENDED tending physician a use as the burial AMENDED X 239.2711/30/06 TT Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnand 23d. Date of delivery 3b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Fetal death Month Year Day Pregnant at time of death 5 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? certificate ✓ Yes 2 1 🗸 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Other₄ this Inpatient ER/Outpatient DOA Nursing Home 5 Residence 6 🗸 Other: Scene 1 V Yes No After 28a. Date of Injury (Month, Day,Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred 1 X Natural 5 Pending Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) determined Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical (Check only To the Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and tile of certifie 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E November 6, 2006 30 Name and address of person who completed cause of death (Item 23a) Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day Year) strar's Signature State 2005 Registrar ORIGINAL

			1 - For State Registrar	State of Maryla		artment of rtificate of		-	giene Reg. N.C.	106	35445
	Physic /Medi		1. Decedent's Name (First, Middle, Last,	Tabor				2. Date of De Month	ath Day	Year 7000	3. Time of Death
1	Exami		4a. Facility Name (If not institution, give		1		, or Location of Dea	th		nty of Death	
	Funeral		Howard County Gen 5. Social Security Number 6. Sec		L s. last birthday)	Colt If Under 1 Year	ımbia ır∐ıf Under 24 Hrs	8. Date of Birt	How		lace (State or Foreign
	Director		234-14-7159 Usual Residence of Decedent	M 2⊠F 88	Yrs.	Months Day	s Hours Min	8. Date of Bin Month, Da March	10,191	Cour	itry)
	death with the Maryland ma 23a or 28a-f ehow rmust be notified at	Funerai Director	10a. State 10b. County Maryland Howard 10e. Street and Number	10c. (Ellic	ott City			10g. Citizen o		Od. Inside City Limits 1 ☐ Yes 2 ☑ No
	23a c	a D	3010 N. Ridge Roa	d Cottage 80	0	210)43		USA		
900	permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 ie marked other than "natural", or Itema 23a or any Injury or other traumatic event, it a Medical Examinat must be anno.	by	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 1 No	Hispanic Origin? (ban, Mexican, Pue Specify:	Specify Yes or No to Rican, etc.)	14. R B Spec	ace - Americ lack, White, city: Wh	
Baltimore, Maryland 21215-0036	ithin 72 h ne. nan "netu	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give	dent's Usual Occi kind of work don DO NOT use retir	e during most of wa	nrking		Business/Inc	,
121	iled w Hygier ther th		17. Father's Name (First, Middle, Last)	4	T	eacher	T 40 M 15 4 M			ication	n —————
and	d be f	o Be	Thomas Yost					me (First, Middle,		ame)	
ary	shoul nd Me mark	P	19a. Informant's Name/Relationship (Ty)	pe, Print)	19b. Mailir	ng Address (Stree	VITGINIA et and Number or R	Mae McN		m State Zin	Code)
Σ	and 2 aith a 127 io		Edward D. Tabor	Husband							City,MD 2104
ore	of He of He fiter		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	20b.		sition (Name of natory or other pl		Date	20c. Location		
Ĕ	Pag iment tant: i		4 □ Donation 5 □ Other (Specify)	Cre	est Law	n Mem.Ga	rden 11/	10/2006	Marrio	ttsvil	lle. MD
Ball	Depart Depart Import eny in		21. Signature of Funeral Service License	Valned	Les F	Name and Add uneral H 630 Edmo	ress of FacilitySte lome of Ca endson Ave	erling As tonsvill enue; Cat	hton S e,Inc onsvil	chwab le, MI	Witzke 21228
	Physician /Medical Examiner	iner	23a. Part1. Enter the disease, or comblishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	ny Sema quence of):	ar the mode of dy	ing, such as cardia	c or respiratory an	est,		Approximate Interval Between Onset and Death
8760, <	ate be executed hysician and he burial-transit	icai Examiner	Cause (Disease or Injury that inflated events resulting in death) Last	Due to (or as a conse	quence of):						
P.O. Box 68	The law requires that the death centificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	Sc. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3	Ectopic pregnand Other (specify)	су			ate of deliver	y Day Year
	w requires that been signed t should be det	þ	Part II. Other significant conditions con	tributing to death but not re	sulting in the un	derlying cause g	iven in Part I.		bacco use co es 2 □ No		e cause of death?
Division of Vital Records,	i: The law requicele has been ; page 2 should	Completed						24a. Was a autops perform	ned2	. Were autop prior to com death? 1 \(\subseteq \text{Yes} \)	sy findings available pletion of cause of
Vita	Physician: this certifice ral director, p	Be	25. Was case referred to medical examiner?	ospital:	-31	1-		ith (Check only or			
o	Phys	<u>د</u>	1 ☐ Yes 2 ☐ No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	1 Inpatient 2	ER/Outpatient 28b. Time of	3L DOX		ome 5 Reside			
sion	utending I death. ctor: After the funer	cation	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	M 1	nyat ork?]Yes 2 □No	28d. Describe ho	w injury occu	rred	
Divi	ital or Ati irs after d rai Direct led in by	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	fy) 			28f. Location (Si City or Town	i, State)		
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	edical	29a. Certifier 12 Certifying Physical (Check only one) 12 Medical Examin	cian: To the best of my know: On the basis of examinand manner stated.	owledge, death ation and/or inv	occurred at the t estigation, in my	ime, date and place opinion, death occu	, and due to the carred at the time, d	ause(s) and mate and place	nanner as sta , and due to	ted. the cause(s)
	with To t	×	29b. Signature and title of Sertifier		. 4 6	29c. Licen	se number	2	9d. Date sign		
	,		Mul	Eus	MD	Do	063653		Novemb	18 ve	2004
	0		30. Name and address of person who con Shawn Evans	npleted cause of death (Ite	n 23a) (Type, F Cedar	Print) Lone Co	0063653 olumbia, 1	MD 21	044		
	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 9 200	32. Registrar's Sign	ature (and I					

DHMH 17 Rev 1/2001

			For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	ertificate of I			ene 2006	35446
			1. Decedent's Name (First, Middle, L	ast)				2. Date of Death Month		3. Time of Death
	Physici /Medic		Ruby M. Taylor					October :		8:23 PM M
	Examin		4a. Facility Name (If not institution, ga	ve street and number)		4b. City, Town, or	Location of Death		4c. County of De	
			4401 Roland Aver		de la la la la la la la la la la la la la	-	timore			
H	Funeral Director		505-10-2381	Sex 7. Age 1 ☐ M 2 🂢 F	91 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y June 9, 1	.915 Ne	rthplace (State or Foreign Jountry) braska
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or I	ocation				10d. Inside City Limits
	with the Maryland a or 28a-f show be notified at	tor	MD		Baltim	ore				1 Yes 2 No
	h the	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What C	Country?
	death with the Maryland ms 23a or 28a-f show Emust be notified at	aiD	4401 Roland Aven	ue #101			21218		USA	
036	ours after des	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ঐ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2M No	ispanic Origin? (Sp In, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: W	ite, etc.
21215-0036	within 72 hours after ene. than "naturel", or ite	Completed	15. Decedent's I (Specify only highest g	rade completed) College (1-4or 5	(Giv	e kind of work done of DO NOT use retired	during most of work. ()	ing	b. Kind of Business	s/Industry unk
N	be filed withing tel Hygiene. d other than event, the M	ပ္ပိ	12 17. Father's Name (First, Middle, Las	0		personell		e (First, Middle, Ma	iden Sumame)	
land		To Be	Dennis Dwy					ilda Jurg		
~	should ind Men i marke umatic	-	19a. Informant's Name/Relationship		19b. Mai	ling Address (Street a				Zip Code)
ĭ Za	and 2		Cameron Northous	e/son	440.	l Roland A	venue #10	01 Baltim	ore, MD	21218
baltimore,	nit. Pages 1 and partment of Healt ortant: If item 2 injury or other 2.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☒ Other (Special Content of the Content	in state	20b. Place of Disp cemetery, cre	osition (Name of amatory or other plac	e) [Date 20	c. Location - City o	r Town, State
Ball	permit. Departimporti		21. Signatur Funeral Vervice Lice Ronald S	Mark, Will	ector, S	22. Name and Addres tate Anato altimore,	ss of Facility Omy Board MD 21201	655 W. B	altimore	Street
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused y one cause on each lin	the death. Do not er	nter the mode of dyin	g, such as cardiac o	or respiratory arrest	•	Approximate Interval Between
- ₆ 1	Physician		Immediate Cause (Final disease or condition	a Alha	nosele	rotic	heart	- disca	M.	Onset and Death
-	/Medical Examiner		resulting in death)	Due to (or as a	a consequence of):			0.000-0		
		-	Sequentially list conditions,	b. Due to for as i	a consequence of).					
	uted J ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
Ď	exec en an	Еха	resulting in death) Last	Due to (or as a	a consequence of):					
68/6U,	icate be executed physicien and s the burial-transit	edicai		d .						
õ	ertifica ling pl	Med	IF FEMALE:							
.c. gox	To the Hospital or Attending Physician: The law requires that the death certificate be execu within 24 hours after death. To the Funeral Infector: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 ☐ Live birth 12 4 ☐ Pregnant at 19 ☐ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	elivery Day Year
 T	s thet ned b e deta	by Pi	Part II. Other significant conditions	contributing to death bu	at not resulting in the	underlying cause give	en in Part I.	23e. Did tobac	co use contribute t	o the cause of death?
cords,	equire en sig ould b	edt	ITYPER	TEN SION)			1 🖺 Yes	2 0 No 3 P	robably 4 DUnknown
Heco	The law re ate has be bage 2 sho	Completed						24a. Was an autopsy performed	d? death?	utopsy findings available completion of cause of
VII	otor.	Bec	25. Was case referred to medical examiner?				26. Place of Death		10 10	
>	hysic this co	2	1 ☐ Yes 2 🔁 No		nt 2 ER/Outpatre		4 Nursing Ho	me 5 Residence	e 6 ☐Other (Spe	ecify)
DIVISION OF	ding F	i.i	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day)	Year) 28b. Time (Work		28d. Describe how i	injury occurred	
<u>s</u>	death ctor: / the	icat	2 Accident investigation 3 Suicide 6 Could not	be One Place of Lain	ry - At home, farm, s		Yes 2 □No	28f Location (Street	st and Number or P	ural Route Number,
2	after Dire	Certification:	4 Homicide determined	building, etc	. (Specify)	reet, ractory, onice		City or Town, S	State)	urar House (vuriber,
	spite hours ineral y filled		29a. Certifier 1 Certifying P	hysician: To the best o	of my knowledge, dea	th occurred at the tim	e, date and place,	and due to the caus	e(s) and manner a	s stated.
	the Hi in 24 the Fu	edical	(Check only 2 Medical Exa	miner: On the basis of and manner stat	examination and/or is	nvestigation, in my op	pinion, death occurr	ed at the time, date	and place, and due	e to the cause(s)
-	With To t	Σ	29b. Signature and title of certifier		C	29c. License			Date signed (Mont	
				James			00522	92 1	0/25/	2006
		-	30. Name and address of person who		eath (Item 23a) (Type		11 101 00	000		
	Sta	i e	Sindhu Thop 31. Date filed (Month, Day, Year)		r's Signature	Luthervi	ше,Md 21	093		
	Registr	_	NOV 0 9 200	6	r's Signature	esa!				

		-	1- For Amend Items 25,27,284 per	Repassor 1970 970 and Certificate of Death	Mental Hygien	2006 35447
	Observation		1. Decedent's Name (First, Middle, Last)	. 111	2. Date of Death Month	3. Time of Death
	Physicia /Medic		Johnny	Utter		18 2006 3:05 PM
	Examin	er	4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat		c. County of Death
			Johns Hopkins Bayoiew Care Cente			Balknore City
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last b. 216–90–0891 44	Yrs. Months Days Hours Min.	. (Month, Day, Yea	9. Birthplace (State or Foreign Country) unk
	and and	-	Usual Residence of Decedent 10a. State 10b. County unk 10c. City, Tox	vn or Location		10d. Inside City Limits
	Maryl f sho	ō		enver		1 ☐ Yes 2 ☐ No
	r 28a	rec	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Country?
	h witi	a D	4853 Grassy Creek Road	28037		USA
21215-0036	s I and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. It has the same 23a or 28a-f show item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Example froat for redifficed at	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ※ No Specify:	specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: white
5-0	72 he	etec	15. Decedent's Education 16a (Specify only highest grade completed)	t. Decedent's Usual Occupation (Give kind of work done during most of wo	orking unk 16b.	Kind of Business/Industry unk
121	within ene. than	ldm	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)		
	filed v Hygie other t	ပိ	unk unk 17. Father's Name (First, Middle, Last)	unk 18. Mother's Na	me (First, Middle, Maide	en Sumame) unk
ano	Mental l	o Be			, , , , , , , , , , , , , , , , , , , ,	,
Maryland	shoul nd Me mark	2	19a. Informant's Name/Relationship (Type, Print) 19	b. Mailing Address (Street and Number or Ri	ural Route Number, City	y or Town, State, Zip Code)
	nd 2 salth an 27 is rrtrau		John Hopkins Bayview Med Ctr	4940 Eastern Avenue	Baltimore	MD 21224
Baltimore,	e = 5		20a Method of Disposition 20b. Place	of Disposition (Name of ary, crematory or other place)	Date 20c.	Location - City or Town, State
Balti	permit. Pag Department Important: any injury once.		21. Signature Superal Stryice Licensee Ronald S. Wade Trector	22 Name and Address of Facility State Anatomy Boa Baltimore, MD 21		Baltimore Street
	Pnysician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do shook, or heart failure. List only one cause on each line. Immediate Sause (Final disease or condition resulting in death) a. Due to (or as a consequence)	not enter the mode of dying, such as cardia of):	c or respiratory arrest,	Approximate Interval Between Onset and Death
60,	ficate be executed physician and is the burial-transit	al Examiner	Sequentially list conditions, it any, loading to immediate cause. Einer Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Dise to (or as a consequence or consequence).	•	\sim	9
68760,	phys phys s the	edical	d		MON APPROVED	
P.O. Box 6	death certii e attending ed for use a	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown	(,E		23d. Date of delivery Month Day Year
	requires that lhe veen signed by th hould be detache		Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobecco	o use contribute to the cause of death?
rds	w requires that s been signed to should be deta	d by	Socurent Programa		1 🗆 Yes	2 No 3 Probably 4 Unknown
of Vital Records,	e law has b je 2 s	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
ita	ician: Th certificate rector, pag	0	25. Was case referred to medical	26. Place of De	ath (Check only one)	10
Ţ <	S S	To B	examiner? 1 X Yes 2 Hospital: 1 npatient 2 □ ER/O	utpatient 3 DOA Other: 4 Nursing H	Home 5 Residence	6 ☐ Other (Specify)
	Jing Pt J. After th funeral		27. Manner of Death T≳Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b.	Time of 28c. Injury at Work?	28d. Describe how in	
Sio	Attending or death. ector: After by the fune	catl	2X Accident investigation 09/09/2005 10	:00 p M 1 ☐ Yes 2 XNo		com motor vehicle
Division	l or Atten after deat Director:	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	arm, street, factory, office	800 blk St	and Number or Rural Route Number,
	pital		Street Continue Physician: To the heat of my knowledge	an death convered at the time date and place	Havre de C	Grace.MD
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge of the basis of examination a and manner stated.	nd/or investigation, in my opinion, death occi	urred at the time, date a	and place, and due to the cause(s)
)	To To con	~	29b. Signature and title of certifier	29c. License number DO 43		Tober 19 2006
			30. Name and address of person who completed cause of death (Item 23a)	(Type, Print) 5505 HOPK RALTIMON	INS TAY	10ber 19 2006 VIEW CIRCLE 21224
	Sta Registr	9 4	31. Date filod (Month, Day, Year) NOV 0 9 2006	Seedle		

			1 - For State Registrar	State of Ma		partment of I ertificate of			giene 006	35448
			Decedent's Name (First, Middle)	Last)				2. Date of Dea	ith	3. Time of Death
	Physicia		Albert Danie	l Williams				November	r 8, 2006	
	/Medic Examin		4a. Facility Name (If not institution,			4b. City, Town,	or Location of Deat		4c. County of De	
	Examin		9045 Old Cou	rt Road		Windso	r Mill		Balti	more
	Funeral			6. Sex 7. Age	(In yrs. last birthd		If Under 24 Hrs Hours Min			irthplace (State or Foreign Country)
	Director		220-32-3042	1 M 2 □ F	70 Yrs	. Working Days	Hours Will	Feb 3,		aryland
P	>-35		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	e Lagation				10d. Inside City Limits
anyla	shov m	_	D 1.							1 Tyes 2 No
₽	-88-1	Director	Maryland Balti	more	Windso			1.	10- 62	21
with t	Den	吉	10e. Street and Number			10f. Zip Code	,		10g. Citizen of What C	ountry?
aath	s 23	Funeral	9045 Old Court	Road 12. Was Decedent E	ever in II S	2124 3. Was Decedent of		Specify Ves or No-	USA 14. Race - Am	nerican Indian
ter d	Het I	Ľ.	11. Marital Status 1 □ Never Married 2X Marrie	Armed Forces?		If Yes, specify Cub	an, Mexican, Puer	to Rican, etc.)	Black, Wh	
Irs af	, e	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 💢 No	Specify:		Specify: W	hite
2 Po	ature		15. Decedent		16a. De	ecedent's Usual Occu	pation	1	16b. Kind of Busines	s/industry
7 H		ple	(Specify only highes: Elementary/Secondary (0-12)	College (1-4or 5-	- lii	ive kind of work done e. DO NOT use retire	during most of wo	prking		
d wit	ar the	Completed	10			vy Equipme	nt Opera	tor	Constru	ction
1	a Hy s oth vent	Be (17. Father's Name (First, Middle, L	.ast)			18. Mother's Na	me (First, Middle,	Maiden Sumame)	
d d	Ment arked artic e	2	Albert W. Will	iams			Eva	Berryman		
2 sho	and Mental Hygens. Is marked other then "naturel; or items 23a or 28e-f show eumstic event, the Medical Exactination or cities of a		19a. Informant's Name/Relationsh	ip (Type, Print)	19b. M	ailing Address (Stree	and Number or R	ural Route Number	r, City or Town, State,	Zip Code)
and	ealth 127 1er tr		Carole A. Will	iams, Wife			t Road W		ill, MD 21	
Ses 1	r ite		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation	3 □Removal from State	cemetery,	sposition (Name of crematory or other pla	· .		20c. Location - City o	r Town, State
Pag	ment ent: ury c		4 □ Donation 5 □ Other (Sp			rematory I			Baltimore,	Maryland
permit. Pages	Department of Health and Memtal Hygene. Important: or Items 23a or 28e-f show important: If Item 27 is marked other then "naturel", or Items 21 are relified at any injury or other treumatic event. If a Medical Exacting must be notified at once.		21. Signature of Funeral Service Thomas Grego	region		Cremation 299 Freder	Society Sick Road	Of Maryla Baltimon	and, Inc. re, Maryla	nd 21228
			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that caused	the death. Do not					Approximate Interval Between
Ph	ysician		Immediate Cause (Final disease or condition	•	tage Dem	entia				Onset and Death
	Medical		resulting in death)	u	consequence of):					
EX	aminer		Sequentially list conditions,		tes Mell		1			Yrs.
D	-	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					
ecute	and -tran	kam	that initiated events resulting in death) Last	c. Hyper	tension consequence of):					Yrs.
o be ex	cian	al E								Yrs.
cate be executed	been signed by the attending physician and should be detached for use as the burial-transit	edical		d. <u>Seizu</u>	res					115.
D X O	iding Ise a:		IF FEMALE:	23c. If yes, outcome of	of pregnancy				23d. Date of de	alivery
eath D	atter for u	clar	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2		3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	у		Month	Day Year
) §	y the sched	Physiclan/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown						
The law requires that the death certif	ned b	by PI	Part II. Other significant condition			e underlying cause gr	ven in Part I.	23e. Did to	bacco use contribute	to the cause of death?
w requires	n sig uld blu		Osteoarthrit	is, Insomnia				1 🗆 Yı	es 2.00 3 □ F	Probably 4 Unknown
§ 5	s bee	Completed	Depression,	Castroesopha	ceal Ref	lux		24a. Was a	an 24b. Were a	autopsy findings available
E all	age	mo	Dept ession,	das er oesopia	Scar Icr	LUA		autops perform	med? death?	
icien:	tifica tor, p	0	25. Was case referred to medical				26. Place of De	ath (Check only or		3 24 110
ysici	is cel	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatier	nt 2 ER/Outpa	tient 3 DOA Ot	ner: 4 🗆 Nursing I	Home 5 Reside	ence 6 Other (Sp	ecify)
P P	h. After this certificate has funeral director, page 2		27. Manner of Death 1 DNatural 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b. Tim		ry at rk?	28d. Describe ho	ow injury occurred	
Attending	or: Al	atk	2 Accident investig	ation			Yes 2 □ No			
IVI.	irect irect	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 28e. Place of Inju	ry - At home, farm, . (Specify)	street, factory, office		28f. Location (Si City or Town	treet and Number or F n, State)	Rural Route Number,
vitel C	urs al							1		
To the Hospitel or Attending Physicien:	within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical		g Physicien: To the best of examiner: On the basis of and manner sta	examination and/o					
To th	To 11	Ž	29b. Signature and title of Tertifier	0.11	11.10	29c. Licen	se number	2	29d. Date signed (Mor	nth, Day, Year)
			MULLEY	Mell	xej 01	D547	49	1	November 9	, 2006
	10		30. Name and address of person v		/ /		D 1 :		200	
	10		Allen Reilly				Baltimor	e, MD 212	228	
	Sta Registr		31. Date filed (Month, Day, Year)	9 2006 32. Registra	r's Signature	Sperker				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Dete of Deeth Month Day **Physician** Jeannette F. Whitney 2006 8:13 PM Nov. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Locetion of Death 4c. County of Death Examiner Columbia Vantage House Health Center Howard If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) Feb. 19,1916 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1□ M 2□ F Alabama 229-44-8955 Director 90 Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haalth and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, its Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2√ No Funeral Director Columbia MD Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5400 Vantage Pt. Road 21044 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 21 No Specify: Specify: White Be Completed by 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Legal Secretary US Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Orlando S. Finch Nancy Bolding 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy W. Vickers 204 Gardner Road, Hague, VA 22469 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Nov.4,06 Falls Church, VA National Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses National Funeral Home 0 duney 7482 Lee Highway Falls Church, VA 22042 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Approximate Interval Between **Dnset and Death Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, U Due to (or as a consequence of) : After this cartificate has been signed by the atte Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No Certification: To 1 ☐ Yes 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Natural 2 Accident 5 Pending To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completally filled in by tha fun 1 Yes 2 No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as stated.

— Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) 413 31. Date filed (Month, Day, Year) State NOV 0 9 2006 Registrar

			For State Registrar	State of Ma			of Health of Death			iene g. N2 0	06	35450
	Physici /Medic		1. Decedent's Name (First, Middle, I	riaht					2. Date of Death Month	Day	Year 2006	3. Time of Death 9:35 AM
	Examir		4a. Facility Name (If not institution, of Mar	yland Medic	el Systes	n Ba	Town, or Location			NA	ty of Death	
	Funeral Director		5. Social Security Number 217-03-4488 Usual Residence of Decedent	Sex 7. Age 1 Dmy 2 F	97 Yr	Months	1 Year If Unde Days Hours	Min.	8. Date of Birth (Month, Day, Mar 22,	Year) 1909	Cou	place (State or Foreign ntry) Maryland
	Aaryland t show	or	10a. State 10b. County Maryland	N/A	10c. City, Town o	or Location	Baltimor	e				10d. Inside City Limits
	with the R a or 28a- be notifi	Direct	10e. Street and Number 2563 Edmondson Ave	enue		10f. Zip	Code 212	223	10	g. Citizen o	What Cou	
92	2 should be filed within 72 hours after death with the Maryland and Mental Hygiane, and Mental Hygiane, is marked other than "naturel", or items 23s or 28s-t show eumatic event, the Medical Examinar must be notified at	y Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Was Decedent E Armed Forces? 1 Yes 2 I	ver in U.S.	13. Was Decedit Yes, spec	ent of Hispanic O ify Cuban, Mexica	rigin? (Spe in, Puerto I	cify Yes or No- Rican, etc.)		ace - Ameri ack, White,	can Indian,
21215-0036	nin 72 hours n. In "naturel", Medical Ex	Completed by	3 Widowed 4 Divorced 15. Decedent's (Specify only highest of the content of the	Year or Dates:	(6	ecedent's Usua	l Occupation		ng	6b. Kind of		dustry
Ind 212	S a b ≥	Be	12 17. Father's Name (First, Middle, La				Longshoren		(First, Middle, M		ıme)	ompany
Maryland		ဥ	19a. Informant's Name/Relationship Betty Wright Wife	,	19b. M	_	(Street and Numb		l Route Number,	City or Town	n, State, Zip	Code)
as a	Pages 1 and ent of Health nt: It Item 27 ry or other tr		20a. Method of Disposition 1 Surial 2 Cremation 3 4 Donation 5 Other (Spe		1		e of I her place)	D		loc. Location		
Balti	permit. Pages 1 Depertment of H Important: It Ite any injury or ott		21. Signature of Aneral Service L	A	12 A	22. Name and	Address of Facilistep Brothers 800 Eutaw P		al Service, F	P. A. 21217		
J. 100/	ate be executed / Medical Examiner Italian and Italian	icai Examiner	23a. Part. Enter the disease, or consock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a	e. ,/ N	ement,	o of dying, such as	s cardiac o	r respiratory arre	st,		Approximate Interval Between Onset and Death
O. Box 68	ath certific ttending p or use as i	Physician/Medi	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 ☐Ectopic pre 5 ☐ Other (spe					ate of deliver	ery Day Year
rds, P	quires that the de n signed by the a uld be detached f	þ	Part II. Other significant conditions	contributing to death bu	t not resulting in t	ne underlying ca	use given in Part	l.		acco use co	ntribute to t	he cause of death?
al Records	The ete h page	Completed							24a. Was an autopsy perform	1	Were auto prior to co death? 1 ☐ Yes	opsy findings available impletion of cause of
Division of Vital	I or Attending Physiclen: The after deeth. Director: After this certificete in by the funeral director, pag	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 Vo 27. Manner of Death 1 Valurat 5 Pending investigat investigat		y 28b. Tin			ursing Hon	Check only one ne 5 Resider 28d. Describe hor	nce 6 🗆 O		y)
Ž	vital or Att urs after de rai Direct lied in by t		3 Suicide 6 Could not determine	building, etc	."(Specify)				City or Town,	State)		al Route Number,
	To the Hospital c within 24 hours at To the Funeral D completely filled in	Medical	(Check only 2 Medical Ex	Physician: To the best of aminer: On the basis of and manner sta	examination and/	or investigation,	it the time, date a in my opinion, de License number	nd place, a ath occurre	ed at the time, da	te and place	, and due to	the cause(s)
)	Z ž Ž Š		29b. Signature and title of certifier	ffer	To A	(D. F	185	554	t Wa	ou Date sign	5,	2006
	\© Sta Registr	_	30. Name and address of person with Tabataba (31. Date filed (Month, Day, Year) NOV 0 9	22 Sci	rath (Item 23a) (Ty The Given 23a) (Ty r's Signature		treet,	Bo	eltimore	, Ma	cylan	d 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Wilson Dorothy C. 8, November 2006 2:48 a M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Pay, Y Aug. 19, Gilchrist Center Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** ^{Yea}(1)932 1 □ M 2 😿 F Months Virginia 229-36-5243 74 Aug. Director Usual Residence of Decedent 10a. State 10b. County 10c. City Town or Location 10d. Inside City Limits 28a-f show notified at Baltimore Director Lutherville 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö must be 328 Lincoln Avenue 21093 U.S.A. or items 23a 72 hours after death Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, traumatic event, the Medical Examiner Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify. þ Specify: White 3 ☐ Widowed 4 ☐ Divorced natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Gollege (1-4or 5+) and Mental Hygiene. Elementary/Secondary (0-12) Registered Nurse Nursing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paul Haven Carr ပ Helen Δ Hollins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i David N. Wilson-husband 328 Lincoln Ave., Lutherville, MD 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley 11/11/06 4 ☐ Donation 5 ☐ Other (Specify) Timonium, MD 21. Signature of Funeral Service Licens Lilliam G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Leukemis TLAIS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed burial-tra Due to (or as a consequence of) physician Physician/Medical the the as IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for 4☐Pregnant at time of death Month Day Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ sign, be c 1 Yes 2 No 3 Probably 4 Unknown Completed has been 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 certificate 1□ Yes 2 **N**o or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 State (Specify) 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of D ath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 12 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident the within 24 hours after death To the Funeral Director: 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 8 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 6565 N. Charles ST ARRON CHAVES, W Browns 2-1202

State

Registrar

31. Date filed (Month, Day, Year)

NOV 0 9

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

32 Registrar's Signature

			1 - For State Registrar	State of Marylar		artmen rtificate					Reg. No	ZUUD	354	52
	Physici /Medic		1 Recedent's Name (First, Middle, L GEORGE	L. WILL	TAN	15			1	2. Date of De Month	Da	1, 200	3. Time of 4:04	
ŧŝ.	Examin		4a, Fecility Name (If not institution, gr. 32/0 UDStm.	ve street and number) OUNT AVE.		4b. City,	Town, or	Location o	of Death			County of Dea	h	
	Funeral Director		229-30-3758	Sex 7. Age (In yrs.	last birthday) 8 Yrs.	If Under Months	1 Year Days	If Under a	24 Hrs. Min.	8. Date of Bir Month, Da	th ly Year	9. Bin	hplace (State or untry)	Foreign
	Maryland	tor	Usual Residence of Decedent 10a. State 10b. County MD NA		y, Town or Lo								10d. Inside Cit	•
	a or 284	I Direc	10e. Street and Number	nt Ave		10f. Zip	Code 216				10g. Ci	tizen of What Co	untry?	
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show strip injury or other traumatic event, the Medical Examinal must be notified at ance.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ fes 2 ☐ No If Yes, Give Year or Dates:		Was Deced If Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spec n, Puerto R	cify Yes or No lican, etc.))-	14. Race - Ame Black, White Specify:		
21215-0036	within 72 hou ene. than "nature he Medicel E	ompleted	15. Decedent's I (Specify only highest g Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	dent's Usua kind of woi DO NOT us	rk done d	luring most)	t of workin	g		are of Business		
Maryland 2	should be filed nd Mental Hygi marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Las Eugene Williams	2				Mago	jie T	(First, Middle,	15			
	es 1 and 2 sh of Health and fitem 27 Is m r other treum		19a. Informant's Name/Relationship Jacqueline Whit 20a. Method of Disposition	e/daughter	2919 Place of Disposemetery, crei	Edgi esition (Nan	e Corr	nb Ci	rcle	1 1	Itin	or Town, State, 2 10/E M ocation - City or	D 21215	5
Baltimore,	permit. Pages Depertment of I Important: if its eny injury or o		Burial 2 Cremation 3 4 Donation 5 Other (Spec	ify) Lou	don	Par K	d Addres	s of Facility	-			timore, Pass Bal	Telli, is a	1739
	Physician /Medical Examiner		23a. Part. First the sease, or co- shoot of ear ailure. List onl Immediar cause (Final disease condition resulting in death)	polications that caused the deat y one cause on each line. METAST Due to (or as a consect	ATTC	ter the mod	e of dying		cardiac or		rrest.	and Da	Approximate Interval Betwoonset and D	e veen
,092		icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conseq c										
.O. Box 68	eth certific	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregns 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c	Ideath 3	Ectopic production of the control of						23d. Date of del Month		'ear
Δ.	w requires that the de been signed by the e should be detached f	by	Part II. Other significant conditions	contributing to death but not res	ulting in the u	nderlying c	ause give	on in Part I.			obacco Yes 2	use contribute to	~ ~	eath?
al Records,	: The law recele has bee	Completed										prior to death?	topsy findings a completion of ca 2 No	vailable use of
Ĭ	Physician: r this certifice ral director.	Be c	25. Was case referred to medical examiner?	Hospital:	500		Othe			Check only o		a 🗆 🗆		
ō	Physic this aral di): To	1 ☐ Yes 2 No 27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o		8c. Injury Work	4 140	rsing Hom	Bd. Describe I		6 □Other (Spe ry occurred	ory)	
Division of Vital	i or Attending effer death. Director: Aftei in by the fune	Certification:	1 Natural 5 Pending 2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	on be as Stock of Injury. At h	Injury ome, farm, str	М	1 🗆 Y	:? /es 2 □ l		8f. Location (: City or Tox		nd Number or Ru e)	ral Route Numb)8 <i>r</i> ,
ت	To the Hospital or Attending Physician: The I within 24 Hours elier death. To the Funeral Director: After this cartificate ha completely filled in by the funeral director, page	Medical Ce		hysician: To the best of my kno iminer: On the basis of examina and manner stated.										
	within To th	Me	29b. Signature and title of certifier	00			. License					ite signed (Mont	• •	
	()		EWI	ele MD	20 1 7		DI	63.	54		11	16/20	106	
_	4		30. Name and address of person who	s completed cause of death (Iter STAGNES	900 QOC	CAT	ON,	AVE	BA	LTIME	RE	16/20 HD	2122	9
	Sta Registr		31. Date filed (Month, Day, Year)	2006 32. Registrar's Signa	iture ?	Joseph	B							

DHMH 17 Rev 1/2001

			ricase	Otata of Manual				•	-	e.
			1_ State	State of Maryla	•			Mental Hyg	200	6 35453
			Registrar		Cert	ificate of	Death		lag. No.	0 00400
	Physic	ian	Decedent's Name (First, Middle, Last)	1 5, U	1:11:	٠,		2. Date of Dea Month		3. Time of Death
	/Medi		Losalino					NOV		06 4:29 AM
	Exami	ner	4a. Facility Name (If not institution, give			•	r Location of Death	. 1 -	4c. County of I	Death / ^
			5. Social Security Number 6. Sec	SPITAL	Inch himbut	If Under 1 Year	MORE,		/0	174
Н	Funeral Director			M 200F	ast birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day	Year)	Birthplace (State or Foreign Country)
			Usuel Residence of Decedent	, ax			1	Marcho	7, 1940)	naryland
	ylan		10a. State 10b. County	10c. C	ity, Town or Loca	ation	~			10d. Inside City Limits
	e Ma	ctor	ma. N	H	10-a	ltim	ne			1 ØYes 2 □ No
	or 28	Oire	10e. Street and Number	, (, .	. 0.	10f. Zip Code			log. Citizen of Wha	t Country?
	De filed within 72 hours after deeth with the Maryland nat Hygiene. ed other than "naturel", or iteme 23e or 28e-1 show event, the Modical Examiner must be notified at	by Funeral Director	4223 010	1 brederic	K Kd.	21	229		U	SA
	er de	- Pu		 Was Decedent Eyer in the Armed Forces? 	J.S. 13. W	as Decedent of H Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - A	American Indian, White, etc.
36	s aft	Y F	1 Never Married 2 Married 3 Widowed 4 Doivorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	10	☐Yes 2☐No	Specify:		Specify:	3/0018
215-0036	hour	ed	15. Decedent's Edu		16a Decede	nt's Usual Occup	ation		16b. Kind of Busin	ner/ledustry
15	n na	Completed	(Specify only highest grade	completed)	(Give ki	nd of work done	during most of work	ing	160. Ball of Busin	ess/moustry
212	yiene.	mo.	Elementary/Secondary (0-12)	College (1-4or 5+)	OF	nien	ASS IS	Tant	20110	exactment
	be filed tal Hygid d other event, I	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle,	Maiden Sumame)	1
lar	should by and Menta marked matic ev	To	Willie U	rebb			Agi	rea	Jone	2
Maryland	2 should and Men is marke aumatic		19a. Informant's Name/Relationship (Ty	oe, Print) Grand	19b. Mailing	Address (Street	and Number of Run	al Route Number	, Cify or Town, Sta	te, Zip Code)
	s 1 end 2 should t Heelth and Mer item 27 is marke other traumatic		naisha Brus	1- daughter	416	Potter	St. ppt	101 150	uto, mo	21229
Baltimore,	Tot H Hiter or oth		20a. Method of Disposition 1 ☐ Gurial 2 ☐ Cremation 3 ☐ R		Place of Disposit cemetery, crema	tion (Name of story or other place	(8)	Date	20c. Location - City	or Town, State
Ë	permit. Peges Department of Important: If it any injury or o		4 □ Donation 5 □ Other (Specify)	1 n	ew Ca	thedra	1 1/19	06	Baltin	noe, md.
3al	Departiment Important		21. Signature of Funeral Service Licens	//	22. 1	Name and Addres			HILTON	
_	40240		X/M/ // // //	nel	(a		arch Fus	ural th	ne bre	to, md, 21229
			23a. Parti. En the disease, or complishock, leaf failure. List only on						est,	Approximate Interval Between Onset and Death
in.	Physician /Medical		Immediate Suse (Final disease or ondition resulting in death)	Aspiro		Phei	imonia	L		Iweek
	Examiner			Due to (or as a consec		1 0-				MI 255
		e e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury	Due to (or as a consec		i ca	cinom	q		1 year
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
ó	e be executed /siclan and e burial-transit		resulting in death) Last	Due to (or as a consec	quence of):	-,,-				
	2 2 0	Icai	C.							
89	The law requires that the death certificat, tie hes been signed by the attending phy age 2 should be detached for use as the	Physician/Med	IF FEMALE:							
Вох	ath ce ttendi	an/	23b. Was decedent pregnant in the past 12 menths?	3c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta		ctopic pregnancy			23d. Date of	,
O.	the a	/sici	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐ Pregnant at time of o	leath 5 □ C	other (specify)			Month	Day Year
P.0	that the do	F	Part II. Other significant conditions con	tributing to death but not res	ulting in the und	orbina couco ou	on in Doct I	22a Did tak	acco use contribut	e to the cause of death?
ds,	signe d be	d by	Breast C		ating in the disc	onykig cause give	airii r ditti.	1 □ Ye		Probably 4 Unknown
Ö	w require	Completed						-		
Re	The lav	m D	hyperte	YIS TUT				24a. Was a autops perforn	v prior	autopsy findings available to completion of cause of
a			25. Was case referred to medical	§ .				1 Yes 2	No 10	res 2□ No
Ë		o Be	examiner?	ospital:	EB/Outpationt	3□ DOA Othe	26. Place of Death		_	
0	a Phys ar this aral di	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injury Work			nce 6 Other (5	респу)
<u>.</u>	Attending r death. ector: After by the funer	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		(? Yes 2 □No			
Division of Vital Records,	r Atte er de recto by tr	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stree	t, factory, office	1:	28f. Location (St. City or Town	reet and Number or	Rural Route Number,
	rs after or et Dire	Cer		, same and a same a same a same a same a same a same a same a same a same a same a same a same a same a same a				Only or rown	, orare)	
	Hospital 24 hours a Funerel I tely filled	Cai	(Grieck only 2[Medical Examin	ician: To the best of my kno er: On the basis of examina	owledge, death o	ccurred at the tim	ne, date and place, a	and due to the ca	use(s) and manner	as stated.
	To the Hospital or Attending Ph within 24 hours after death. Xo the Funerel Director: After thi completely filled in by the funeral:	Medicai	Unite)	and manner stated.						
	₽ ₹ ₽ 8	-	29b. Signature and title of certifier	lais MI		29c. License			d. Date signed (M	
	7		po crewy	7			10965		Nov 0	7 2006
4	5		30. Name and address of person who con Br NEERATA BOD		n 23a) (Type, Pri	1+05P1	TAL			
	Sta	te	31. Date filed (Month, Day, Year)	32. Rigistrar's Signa						
E.	Registr		NOV n 9 200	117	iture	Als.				

ROSALIND

WILLIAMS

		ricas	State of Ma					Mental Hy		gibic.	
		1 - State	State of Mic	•	Certificat			•	Reg. No.	106	35454
Physi	* ician	1. Decedent's Name (First, Middle,	Last)			ARN		2. Date of Dea		Year 2006	3. Time of Death
	dical	4a. Facility Name (If not institution,		TCUM			ocation of Dea		4c. Co	unty of Death	()
Exam	niner	110 Sweetser Roa				nthic			A	nne Ar	undel
Funera	al		6. Sex 7. Age	e (In yrs. last birt	Months		f Under 24 Hr Hours Min	8. Date of Birt	h y, Year)	9. Birthp	lace (State or Foreign
Directo	or	091-26-2283	1 □ M 2 0 E	94	Yrs.	Days		07-31	-1912		MD
and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Towr	n or Location					1	0d. Inside City Limits
Maryl -1 ehc	tor	MD Anne A	rundel	Lintl	nicum						1 ☐ Yes 2 🖾 No
death with the Maryland ms 23s or 28s-1 ehow firtuet be notified at	Funeral Director	10e. Street and Number			10f. Zip	Code			10g. Citizen	of What Cour	itry?
ath wil	rai	110 Sweetser Roa				.090			U.S		
er des	nue	11. Marital Status	12. Was Decedent I Armed Forces?		13. Was Dece	dent of Hisp cify Cuban,	anic Origin? (Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14.	Race - Americ Black, White,	
OU36 hours after turel, or its	by F	1 Never Married 2 Marrie 3	d 1 ☐ Yes 2 X N If Yes, Give Year or Dates:	40	1 🗆 Yes	2X No .	Specify:		Sp	ecify: W	hite
		15. Decedent		16a.	Decedent's Usu	al Occupation	on	ortina	16b. Kind	of Business/Inc	dustry
within 72 ene.	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5	+)	(Give kind of wo life, DO NOT u		ing most or we	Jiking	**	0	
filed w Hygien other th		17. Father's Name (First, Middle, L	2		Homemake		9 Mother's Na	ame (First, Middle,		Owner	
/IGNG	To Be	Seth Hance Linth						atilda Pe	_	,	
Maryla d 2 should th and Men T is marke	-	19a. Informant's Name/Relationsh	ip (Type, Print)	19b.	Mailing Address	(Street and	d Number or F	îural Route Numbe	r, City or To	wn, State, Zip	Code)
- C - N L		Mr. John Warner	Sr. / son	-			idge R	oad; Pasa			
IMOFE, Pages 1 a ment of Hec ant: if item ury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation		cemeter	Disposition (Nar y, crematory or o	other place)		Date		on - City or To	
Saltimor Dermit. Pages Department of Important: If it	٠	4 □Donation 5 □Other (Sp 21, Signaty 6 Fureral Service L		•	eake Cre			08-2006 ingleton			
D Bed A	a	I Life	-	101411				Glen Bu			
* *		23a. Part1. Enter the disease, or of shock, or heart failure. List of	complications that caused nly one cause on each lin	the death. Do r	not enter the mod	le of dying,	such as cardia	ac or respiratory ar	rest,	^	Approximate Interval Between
Physicia		Immediate Cause (Final disease or condition resulting in death)	_aL	ymp	homa	, U	Vide	y meta	STAR	1	Onset and Death
/Medica Examine		resulting in death)	Due to (or as	a conseque (ce	of):	/		1			O
	Je Je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence	of):						
acuted ind transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c								
6 be executed sician and burial-transit	calEx	tesuring in death, cast	Due to (or as	a consequence of	of):						
certificate nding physics as the	olbe		d								
ath certi	Iclan/Med	IF FEMALE: 23b. Was decedent pregnant	23c. tf yes, outcome	of pregnancy 2 Fetal death	3 □Ectopic pi	rognancy			23d.	Date of delive	•
e death the atter	sicia	in the past 12 months? 1 Yes 2 No 9 Unknown	4☐Pregnant at 9☐Unknown		5 Other (sp					Month	Day Year
that th	Physi	Part II. Other significant condition	s contributing to death bi	ut not resulting in	the undertying o	ause given	in Part I.	23e. Did to	bacco use	contribute to the	ne cause of death?
w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the buriat-transit	d by	18 (3)		·				1 🗆 Y	'es 2□N	o 3∏Prob	ably 4 Unknown
ecords law requires as been sign	ompleted							24a. Was	an 2	4b. Were auto	psy findings available mpletion of cause of
The The ete h	Com							perfor	med?	death? 1 ☐ Yes	
OT VICAL Physicien: T this certificet ral director, pi	Be	25. Was case referred to medical examiner?	Hospital:			Othor		eath (Check only o	ne)		
Phys Phys	J.	1 Yes 2 No 27. Manner of Death	28a. Date of Injur	v 28b. T	tpatient 3 DC	28c. Injury at	4 🗆 Nursing	Home 5 Resid			()
Attanding r death. actor: After	atlor	1 Natural 5 Pending 2 Accident investiga	(Month, Da)	Year) In	njury M	Work?	s 2∐No				
INISION or Attending after death. Director: After	Certification:	3 Suicide 6 Could no 4 Homicide determine		ury - At home, fa	rm, street, factor	y, office		28f. Location (S City or Tow		umber or Rura	l Route Number,
urs aft	Cer										
DIVISION OF To the Hospitel or Attanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	dlcal	29a. Certifier (Check only one) Certifying Certifying Certifying Certifying	Physician: To the best of xaminer: On the basis of and manner sta	examination and	, death occurred d/or investigation	at the time, , in my opin	date and plac ion, death occ	e, and due to the curred at the time, of	ause(s) and date and pla	I manner as st ce, and due to	ated. the cause(s)
To the within To the	Me	29b. Signature and title of certifier	0 1	1	290	c. License n	umber		29d. Date si	gned (Month,	Day, Year)
		Amich	7,09	ymie	-m	1)	214:	38	NO	V 08	2006
10	2	30. Name and address of person w	no completed cause of d	eath (Item 23a) (Type, Print)	FID	ISF +	46HWA	A.	NINAPO	2006 US MD4401
and the same	State	31. Date filed (Month, Day, Year)	2006 32 Registra	ar's Signature	Cracke) I C N	,,,,,	19/1/011	(/ ' '	VW/T U	-171-17
Regis		MOA 0 8	2000	and the	la la constante						

Physicia	ın	Registrar 1. Decedent's Name (First, Middle, Last) John Butler Williams					1	2. Date of Death Month November 8	Day Year	3. Time of Death 11:50 A M
/Medica Examine		4a. Facility Name (If not institution, give s Stella Maris Hospice	treet and number)		4b. City	, Town, or Loca 11Um	tion of Death		4c. County of Deat Baltimore	
uneral irector		5. Social Secu 8405 ber 6. Sex 215-14-8 685	(M 2□F 7. Age (Ir	yrs. last birth	Months		nder 24 Hrs. urs Min.	8. Date of Birth (Month, Day, September		hplace (State or Foreign aryland
or 28e-f show be notified at	ō	Usual Residence of Decedent 10a. State 10b. County Maryland N/A	10	Baltin						10d. Inside City Limits
23a or 28e ust be notif	Funeral Director	10e. Street and Number 4800 Anabia Avenue			10f. Z	p Code 21214		10	g. Citizen of What Co USA	ountry?
0 5	2	11. Marital Status 1 Never Married 2X Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 XXY es 2 ☐ No If Yes, Give Year or Dates:	rin u.s. WWII	13. Was Dece If Yes, spe 1 \(\text{Yes}		ic Origin? (Spe oxican, Puerto I ecify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: Whi	e, etc.
Deperment of heelin and Mental Hyglene. Important: if item 27 is marked other then "neturet; eny injury or other treumatic event, the Medical Exe	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)			ual Occupation ork done during use retired) Electrici		ng 1	6b. Kind of Business Martin Marie	
rked otheric avent,	To Be C	17. Father's Name (First, Middle, Last) John B. Williams					Mother's Name Grace Co	(First, Middle, M	laiden Sumame)	
elm and r 127 is me er treume		19a. Informant's Name/Relationship (Ty) Johanna Williams/Wife		480	00 Arabi	a Avenue		re Marylar	City or Town, State, and 21214	Zip Code)
nent of the int: if item iry or oth		20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		20b. Place of C cemetery, Gardens (11/1		oc. Location - City or Baltimore Mar	
imports eny inju		21. Signature of Funeral Service License License	. Wilton		Leonard 5305 Ha	nd Address of I J. Ruck, rford Roa	inc Înc d Balti	more Maryl	and 21214	
ysician Medical medical medical medical medical medical	cai Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence of	n): n)-	JE				
/ the ettending phys ched for use es the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetel death	3 ⊟Ectopic 5 ⊟ Other (23d. Date of de Month	livery Day Year
9 9	۵	Pair II. Other significant continuous continuous to death out not resulting in the underlying cause given in rare.								
cete has been s page 2 should	Completed							24a. Was ar autops perform 1 Yes 2	/ prior to	utopsy findings available completion of cause of 2 No
this certificete al director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	lospital:	2 ER/Outp	patient 3 🗆 🛭	Other: 4	☐ Nursing Ho		nce 6XOther (Spe	ncify) HOSPICE
fler	Certification:	27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	me of jury M	28c. Injury at Work? 1 Tyes	2 □ No		w injury occurred reet and Number or R	ural Route Number		
within 24 hours effer death. To the Funerel Director: A completely filled in by the fu			28e. Place of Injury building, etc. (Specify)	death Jeeure	id at the time, do	ste and plane	City or Town	, State) use(s) and manner a	s stated
the Fur	ledicai	one)	ner: On the basis of ex and manner stated	amination and						
	Σ	29b. Signature and title of certifier			2	9c. License nun	nuer nuer	29	3d. Date signed (Moni	un, Day, Year)

Registrar

06-08085 Frank Williams

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 35456

		1- For State Certificat	e of Death	Reg. No.	
Physici	an/	Decedent's Name (First, Middle,Last)		Date of Death Month Day Year	3. Time of Death 1110 hrs
al Exami	ner	Frank Williams 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deatl	Month Day Year October 27, 2006	
		3307 Dudley Avenue	Baltimpre	To. Godiny of Bo	
Funeral		5. Social Security Numbeunk 6. Sex 7. Age (In yrs. last birtho	ay) If Under 1 Year If Under 24Hr		Birthplace (State orunk
Director		1XM 2 F 55	Yrs. Months Days Hours Mir		eign Country)
		Usual Residence of Decedent			
a a by		10a. State 10b. County 10c. City, Fown or			10d. Inside City Limits 1 X Yes 2 No
land Fshore	tor	1110	timore	10g. Citizen of What Co	
ie Maryland or 28a-f show fied at once.	Director	10e. Street and Number	10f. Zip Code		ountry?
th th 23a noti		3307 Dudley Avenue 11. Marital Status unk 12. Was Decedent Ever in U.S. 1	21213 3. Was Decedent of Hispanic Origin? (S	USA	erican Indian, Black,
death wi or items	Funeral	1 Never Married 2 Married Armed Forces?	If Yes, specify Cuban, Mexican, Puerto		
E 0 7		3 Widowed 4 Divorced If Yes 2 1 No If Yes 2	1 Yes 2 X No specify:	Specify:	black
5-0036 led within 72 hours after bygiene. other than "natural", of the Medical Examiner 1	d by	15. Decedent's Education (Specify only highest grade completed) 16a. De	cedent's Usual Dccupation (Give kind of ring most of working life. DD NDT use rel		s/Industry unk
16 n 72 hou an "nat ical Exa	lete	Elementary/Secondary (0-12) College (1-4 or 5+)	and the state of t		
5-0036 iled within 72 Hygiene. I other than the Medical	Completed	unk unk 17. Father's Name (First, Middle, Last)	un 18.Mother's Nam	e (First, Middie, Maiden Surname)	unk
	9	17.1 duters Name () ils., Micole, East)	GII Iomono o nam	o (i mag mada) madan da mamay	a.i.
	To B	19a. Informant's Name/Relationship (Type, Print)	Mailing Address (Street and Number or	Rural Route Number, City or Town, Sta	ate, Zip Code)
ages I and 2 shount of Health and Note: If item 27 is not the transmitter other transmite.			lll Penn Street Bal		
ore, N s l and of Healt If item			Disposition (Name of cemetery, y or other place)	Date 20c. Location - City	or Town, State
Page ment c		4 Donation 5 X Other Specify: in state			
Baltimore, permit. Pages I at Department of Her Important: If ite		21. Signature of Funeral Service Licensee Ronald S. Wade, Director	22. Name and Address of Facility State Anatomy Boar	d 655 W. Baltimor	e Street
hysician		23a. rart I. Enter the disease, or complications that caused the death. Do not a	Baltimore, MD 212 enter the mode of dying, such as cardiac		Approximate Interval
/Medical		hilure. List only one cause on each line.			Between Onset and Death
Examiner		Immedia C use (Final disease or condition resulting in death) a. Atheroscierotic Cardiovascula a. Atheroscierotic cardiovascula a.			
	_	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	nine	cause. Enter Underlying Cause			
sit sit	Examiner	(Disease or injury that initiated events resulting in death) Last			
760, cate be executed physician and the burial - transit		d			
760, icate be ex physician the burial	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of deliving	erv
		23b. Was decedent pregnant in the past 12 months?	Fetal death 3 Ectopic pregn		Day Year
Box 687 e death certifi the attending	Physician	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)		
). By the de by the	Phy	Part II. Other significant conditions contributing to death but not resulting i	n the underlying cause given in Part I.	23e. Did tobacco use contribute	to the cause of death?
ords, P.O. Box 68' w requires that the death certifications is been signed by the attending should be detached for use as:	l by	·		1 Yes 2 No 3 P	robably 4 🗸 Unknown
rds, requir been s	Completed				autopsy findings available o completion of cause of
COI e law te has ge 2 st	ld m			performed? death	
tal Rection: The certificate ector, page		25. Was case referred to medical	26.Place of Death (Check		
of Vital Records, g Physician: The law requinment to the relation of the relat	To Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outp	patient 3 DOA Dther Nursi	ng Home 5 Residence 6 🗸 Oth	er: Scene
		(Month, Day, Year)	ne of Injury 28c. Injury at Work?	28d. Describe how injury occurred	-
ivision or Attend after death. Director:	atic	2 Accident Investigation	1Yes 2No		
Division tal or Attendirs after death. al Director: /	Certification:	Suicide Could not be determined (Specify)	n, street, factory, office building, etc.	28f. Location (Street and Number or I or Town, State)	Rural Route Number, City
E 8 5 E i	ပိ	4 Homicide 29a. Certifier Certifician Physician To the best of my knowledge death	occurred at the time, date and place, and	d due to the cause(s) and manner as st	arted
To the Hos within 24 ha To the Fun	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or invitable and manner stated.	estigation, in my opinion, death occurred	at the time, date and place, and due to	the cause(s)
F. 3 F. 8	Me	29b. Signature and title of certifier	29c. License number	29d, Date signed (N	fonth, Day, Year)
		Theodon U. Try JR, M. B	O.C.M.E.	October 27, 20	06
		30. Name and address of person who completed cause of death (Item 23a)		MD 24204	
		Theodore M. King, Jr., MD. Assistant Medical Examin 31. Date filed (Month, Day, Year) 32. Registrar's Signature	er 111 Penn Street, Baltimor	e, IVID 21201	
S	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	20162		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day 2006 **Physician** Morta Young /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 4713 Dan 5. Social Security Number)artford Avenue Daltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 M 2 F 216-20-6454 Usual Residence of Decedent Vre 93 03/31/1913 Director Georgia permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event the Madian. 10d. Inside City Limits 10c. City, Town or Location 10a State 10h. County 1 NYes 2 No Director NIA baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Avenue 21229 Daetford Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Black 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) A:de Baltimore NIA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Braswell ဂ sal lie Holmes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ave, Baltimore, MD 21229 Bowman (daughter 4713 Daetford 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/09/2006 Baltimore, MD 22. Name and Address of Facility Youghn C Greene Funeral SVC 5151 Batto Watt Pike Baltimore 21. Signature of Funeral Service Licensee lauch Pike Baltimore, MD 21229 Freene Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. alder Immediate Cause (Final disease or condition resulting in death) vasala **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): physician s the burial Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4□Pregnant at time of death 5 ☐ Other (specify) Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1□ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s has certificate or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 2 No 1 ☐ Yes ို 1 Inpatient this 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death within 24 hours after death.

To the Funeral Director: After completely filled in by the funera Certification: To the Hospital or Attending 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and maniper stated. 29b. Signature and title of certific 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 123a) (Type, Print) Choice Cook

Registrar

State

720 32 Registrar's Signature

1-	For State Registrar
----	---------------------------

			1 - State Registrar		Cei	rtificate of l	Death		Reg. No.		
			1. Decedent's Name (First, Middle	Last)				2. Date of D		Vaar	3. Time of Death
	Physici		Mary Tobin An	derson				Month Octobe	Day	2006	1:00 P M
E. S.	/Medic Examir		4a. Facility Name (If not institution,			4b. City, Town, or	Location of I			ounty of Death	
	LAdiiii	ıcı	Calvert Count	v Murging C	ontor	Prince	Frade	rick		Calvert	County
-	Funeral				e (In yrs. last birthday)	If Under 1 Year	If Under 24	Hrs. 8 Date of Bi	rth	9. Birth	place (State or Foreign
	Funeral Director		578-62-1484	1 □ M 2 X F	00 Yrs.	Months Days	Hours	Min. (Month, D. Feb. 1	a <i>y, Year)</i> 1 . 190		York
			Usual Residence of Decedent		56			# CD • 11	1, 100	11017	10111
	iand		10a. State 10b. County		10c. City, Town or Lo	cation					10d. Inside City Limits
	Mary if eh	ō	MD Calver	t County	Dunkirk						1 ☐ Yes 2 No
	15e	ec	10e. Street and Number	t country	Duintin	10f. Zip Code			10g. Citize	n of Whal Cou	ntry?
	with or	۵	3055 Hickory R	idae Road		20754			TI	S.A.	
	eath	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.S. 13.1		ispanic Origin	? (Specify Yes or N		. Race - Ameri	can Indian,
	Items	5	1 Never Married 2 Marri	Armed Forces	No	f Yes, specify Cuba	n, Mexican, F	n? (Specify Yes or No Puerto Rican, etc.)		Black, White,	, etc.
Maryland 21215-0036	d within 72 hours after death with the Maryland jiene. In then "naturel", or Items 23e or 28e-f ehow The Wedgal Exami, or must be notified at	by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1⊡Yes 2 <mark>X</mark> No	Specify:		S	pecify: W	nite
ş	hou		15. Decedent	s Education	16a. Dece	dent's Usual Occupa	ation		16b. Kind	of Business/In	ndustry
15	⊆ 2	olet	(Specify only highes		(Give	kind of work done o	during most o I)	f working			
12	e filed within II Hygiene. other then "	Completed	Elementary/Secondary (0-12)	College (1-4or		Education	on Teac	cher	D.C.	Board o	of Education
0	∰ ¥ # # # # # # #	Ö	17. Father's Name (First, Middle, I	ast)				Name (First, Middle			
an	D 2 D .	To B	John E. Tobin				Mom	v Gregory			
2	should od Mer marke matic	F	19a. Informant's Name/Relationsh		19b. Mailir	ng Address (Street		or Rural Route Numb	per, City or T	Town, State, Zij	o Code)
<u>E</u>	od 2 s lith ar 27 ie r trau		Mary F. Oursle			563590		Rd., Dunki			
	9 E E		20a. Method of Disposition	1 (Daugiite.	20b. Place of Dispo	sition (Name of		Date		ation - City or To	
ઠ્	in it of or o		1 ⊠ Burial 2 ☐ Cremation		cemetery, crer	matory or other plac	PC1	t. 27,	1220	7.000	57 (1957)
ij	tmer tant dury		4 ☐ Donation 5 ☐ Other (Scale) 21. Signature of Fund 1 2 2 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3		Resurrect	ion Cemet	terv	2006	Clint	on, Mai	yland
Baltimore,	permit. Pages Department of Pimportant: if its eny injury or of once.			osee				Lee Funera			
	00500		Michael W.	hee.				ryland Bly		wings,	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause only one cause on each l	the death. Do not ent ne.	er the mode of dyin	g, such as ca	irdiac or respiratory a	arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	PUL	MONARY	EDGM 1	R				Oliset and Death
	/Medical		resulting in death)	Due to (or as	a consequence of):	<u> </u>					
	Examiner		Comportially list conditions	n con	MOVANY a consequence of): 2637 VE	HEART	PAI	LUNG			
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of):						
	cuted	Examine	Cause (Disease or injury that initiated events	с							
ó	en ar rial-t		resulting in death) Last	Due to (or as	a consequence of):						
68760,	ysici	cal		d							
89	eath certificate be executed attending physicien and for use as the burial-transit	/Medical					·				
Вох	h cer endir		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		Ectopic pregnancy			23	d. Date of deliv	
	0 0	Physician	in the past 12 months? 1 □ Yes 2 □★6	4 ☐ Pregnant a		Other (specify)				Month	Day Year
P.0	t the by th	hys	9 Unknown	9□ Unknown							
	The law requires that the deste has been signed by the a bage 2 should be deteched to	by P	Part II. Other significant condition	ns contributing to death t	out not resulting in the u	nderlying cause give	en in Part I.	23e. Did	tobacco use	contribute to t	he cause of death?
ğ	auire n sig ald b		DEMENTIR	, CHRAMIC	OBSTRUCTURE				Yes 2	No 3 ☐ Proi	bably 4 □Unkpewn
20	w require been si should b	lete				0	156751	24a. Was	s an	24b. Were auto	opsy findings available
Re	The lavelete hes	Completed							onmed?	prior to co death?	empletion of cause of
<u>_</u>								1 ☐ Yes	30 No	1 🗆 Yes	2□ No
₹	ystcian: is certifications director	Be	25. Was case referred to medical examiner?	Hospital:		Othe	or	Death (Check only			
of Vital Records,	Physician: this certific ral director,	2	1 ☐ Yes 2 No 27. Manner of Death	1 ∐ Inpati	ent 2 ER/Outpatier	IL 3L DOA	4 M INUISI	ing Home 5 ☐ Res 28d. Describe			(y)
Ë	ling After uner	0	1 Natural 5 ☐ Pending	(Month, Da		Worl	k? Yes 2 ⊡ No		now injury c	,ccarred	
Sign	Attending or death. ector; After by the fune	cat	2 Accident investig 3 Suicide 6 Could n	ot be	445		162 5 140		(Ctrant and)	Alumbas as Ous	at Court Muse to a
Division	or At after Direct in by	ertification;	4 Homicide determi	and 286. Place of In	ury - At home, farm, str c. <i>(Specify)</i>	еет, гастогу, оптсе		City or To	wn, State)	vumber or mun	al Route Number,
	urs a	O									
	• Hospital	edical	(Check only 2 Medical I	Physician : To the best Examinar : On the basis o	f examination and/or in						
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: Atter th completely filled in by the funeral	Med	one)	and manner st	ated.	29c. License	a number		29d Date	signed (Month,	Day Year)
	To To		29b. Signature and title of certifier	/1 N/	1 1 1						
7			Hym	2 W//C	ey /	D502	233		Octob	er 25,	2006
	11/2		30. Name and address of person	the state of the s				.1_2_7 35	7 - 1	0075 4	
	10		Glynis A. Mood		845 Town Ce	enter Blvo	a., Du	nkirk, Mar	yrand	20754	.,
	Sta		31. Date filed (Month, Day, Year)	32. Regist	Signature	dearle s					
1	Registr	ar	OCT	2 6 2006	They Is	A STATE OF					

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

OCT 2 4

2006

32 Registrar's Signature

			1 - For State Registrar	State of Ma	arylan		artment o			nd Me		giene	1000	35	5460
	Physici /Medio Examir	al	1. Decedent's Name (First, Middle, Las PAULINE C 4a. Facility Name (If not institution, give T923 KN1C1+	Street and number)			HIN 4b. City, Tov	wn, or La	ocation of	Death	2. Date of Dea Month Oc To h	Day 4c.	County of D	0603 eath	ne of Death
• 3	Funeral Director		5. Social Security Number 246–30–3550 1 Usual Residence of Decedent	9X ☐ M 2 🔏 F	e (In yrs. I. 79	ast birthday) Yrs.	If Under 1 Y Months D		f Under 2 Hours		3. Date of Birt Month, Day 04/25/1	927	9. 8	Birthplace (S Country) N	tate or Foreign C
	he Maryland	ector	10a. State 10b. County MD CECIL		1	, Town or Lo	3							1 🗆	de City Limits Yes 2\(\frac{1}{2}\) No
	h with t		10e. Street and Number 792B KNIGHTS ISLA	ND ROAD			10f. Zip Co 2191					10g. Citi US	izen of What SA	Country?	
9800	n 72 hours after death with the Maryland "natural", or Iteme 23a or 28a-1 ehow calcal Expolicer must be notified at	d by Funeral Director	11. Marital Status 1 □ Nøver Married 2 🕅 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:			Was Decedent f Yes, specify		anic Origi Mexican, Specify:	in? (Spec Puerto Ri	ify Yes or No- ican, etc.)		14. Race - Ai Black, W Specify: WI	hite, etc.	an,
21215-0036	d within giene. r then "	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5	+)	III e.	lent's Usual O kind of work d DO NOT use n OPERA	etirea)			7		nd of Busine		
Maryland	d la d	To Be (17. Father's Name (First, Middle, Last) WILLIAM HENRY OL						GENE	EVA A					
	12 and 12		19a. Informant's Name/Relationship (7 TODD ALPHIN/SON	ype, Print)			ng Address (St KNIGHT								
Baltimore,	s 1 a of Hei item othe		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		C6	ace of Dispo	sition (Name of natory or other CE CREM	of place)	1	Da	te	20c. Lo	cation - City	or Town, Sta	
Balt	permit. Page Department of important: if any injury or ance.		21. Signature of Funeral Service Licen			FĮ	Name and A LLLOWS, SO SPEE	HEI R RC	FENB	SEIN CHES	AND NE	WNAM N. M	I FUNEI D 2162	RAL HO	ME, PA
	Physician Physician Medical Medical Examiner (the prival-transit physician and physician and physician and physician are provided by the physician and physician are provided by the phys	al Examiner	23a. Jant. Enter the disease, or compands, or compands, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leads to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Colo M Due to (or as a Due to (or as a	a consequ	rence of):	er the mode of	dying, s	such as ca	ardiac or i	respiratory and	rest,		Approx Interva Onset	irmate I Between and Death
	death certific e attending p od for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	2 ☐ Fetal	death 3	Ectopic pregn					2	23d. Date of o	lelivery Day	Year
	law requires that the as been signed by th 2 should be detache	by	Part II. Dther significant conditions co	ontributing to death bu	ut not resu	lting in the u	nderlying caus	e given ii	n Part I.		23e. Did to		se contribute		e of death?
000	The ste h page	Completed									24a. Was a autop: perfor	sy	24b. Were prior t death	o completion	ings available of cause of
Vit.	Physician: The this certiticate hi ral director, page	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🕅 No	Hospital: 1 ☐ Inpatie	nt 2∏F	ER/Outpatien	t 3 DOA	Other			Check only or 5 12 Resid		CO15 (C		
ion oi	£ = =	ation; T	27. Manner of Death 1 Vatural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	у	28b. Time of Injury	28c.	Injury at Work?		28	d. Describe h			овспу)	
Divis	P Sign	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubulding, etc	: (Specify))				28	City or Tow	n, State)			Number,
	To the Hospital within 24 hours of To the Funeral completely tilled	edical	29a. Certifier (Crieck only one) 1 A Certifying Physical Examone)	rsician: To the best of iner. On the basis of and manner sta	examinati	vledge, death ion and/or inv	occurred at the estigation, in r	ne tim <i>e</i> , o my opinio	date and on, death	place, and occurred	d due to the c at the time, d	ause(s) late and	and manner place, and d	as stated. ue to the cau	ise(s)
)	Mithii To th	Me	29b. Signature and title of certifier Forkos				D	dense nu	umber /	14			e signed (Mo		
r	ns	1 14	30. Name and address of person who of	ompleted cause of de	eath (Item	1/	Print)	EI	1k to	1	70				
	Sta Registr		31. Date filed (Month, Day, Year) OCT 18	32. Regional 2006	ır's Signati		Sarati i	- /	,	, .					

State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day Year MORTON EDWARD BACHRACH OCTOBER 13, 2006 12:47 PM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death DORCHESTER GENERAL HOSPITAL CAMBRIDGE DORCHESTER 8. Date of Birth (Month, Day, Year OCT 13, 19 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 1 Year | If Under 24 Hrs. | Days | Hours | Min. | **Funeral** 9. Birthplace (State or Foreign Months 1**X** M 2 □ F 578-18-6181 85 Director Yrs WASHINGTON, D.C 1921 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ahow 10d. Inside City Limits the Medical Examiner must be notified at MARYLAND MONTGOMERY EASTON Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6109 COUNTRY CLUB DRIVE 238 21601 UNITED STATES OF AMERICA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. hours after 1X∑Yes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married 5 Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Š Specify: WHITE 3X Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) 5+ PHARMACIST PHARMACY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ould be f Mental le marked HARRY BACHRACH BESSIE SOPHER 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is m eny injury or other treum once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOAN-LEE SLATKIN/DAUGHTER 6109 COUNTRY CLUB DRIVE, EASTON, MARYLAND Itimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State comagney command (v of other place)
ADAS ISRAEL
CONGREGATION CEMETERY 10/19/2006 WASHINGTON, D.C. t⊠ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signate of Funeral Service Licensee 22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1170 ROCKVILLE PIKE, ROCKVILLE, MARÝLAND 20852 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a ASPERATION OF FOOD /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed Due to (or as a consequence of): burial-Box 68760, Physician/Medical the as ettending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 Other (specify) ed by the o 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ۵ ARTERIOSCLEROTIC HEART DISEASE Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X☐ Unknown ACUTE RENAL FAILURE 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autopsy of Vital 1 Yes 2 XNo 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1A Yes 2 No 1 🗌 Inpatient 2 XER/Outpatient 3 DOA this : After this funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division s after dea... Natural 5 Pending 10/13/2006 12:14P M 2X Accident investigation 1 ☐ Yes 2 🔯 No CHOKING ON FOOD 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
MALLARD BAY NURSING HOME 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 9 filled in I CAMBRIDGE, MARYLAND To the Hospital within 24 hours a To the Funerel C ¥© Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29b. Signature and title of certifie LOWE 29c. License number 29d. Date signed (Month, Day, Year) 015136 D0063359 OCTOBER 13, 2006 MD Wis 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. MAHUBA AKHTER, 300 AURORA STREET, CAMBRIDGE, MARYLAND 31. Date filed (Month, Day, Year) 32 Pegistrar's Signature State 2 5 Registrar

			For State Registrar	State of	of Marylan	•	artment rtificate			and Me		giene Reg. No.	006	35	462
	Physicia		1. Decedent's Name (First, Middle,		ia BRICI	KEL					2. Date of De Month October	Day	Year 2006	3. Time	
,	/Medic Examin		4a. Facility Name (If not institution,	give street and nu	mber)		4b. City,	Town, or	Location o				inty of Death		
			Casey House Mon	tgomery				ckv1				Mor	itgome		
	Funeral Director		5. Social Security Number 124-09-2590	.Sex 1 □ M 2 X F	7. Age (In yrs. 87	last birthday) Yrs.	If Under Months	1 Year Days	If Under a	Min.	B. Date of Birt (Month, Da (ay 16,	y, Year)	Cou	place (State ntry) York	or Foreign
	pu ,		Usual Residence of Decedent 10a. State 10b. County		10c Cit	v. Town or La	cation							10d. Inside	City Limits
	Maryla 1-f ehov	tor	Maryland Montg	omery	100.01	Kensi									s 2X No
	with the 3e or 28e	i Directo	10e. Street and Number 3620 Littledale	Road #3	13		10f. Zip		895			10g. Citizen Un it ed	of What Cou		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hyglene. Depertment of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or Items 23s or 28s-f show simportant: if Item 27 is marked other than "natural", or Items 23s or 28s-f show appringing or other traumatic event, Ite M. diral Examinat must be notified at another.	by Funerai	11. Marital Status 1 □ Never Married 2 □ Marrie 3 □ Widowed 4 □ Divorced	Armed F	2 ∑X No ive		Was Deced if Yes, spec 1 ☐ Yes 2		spanic Orion, Mexican Specify:	gin? (Spec i, Puerto R	ify Yes or No ican, etc.)		Race - Ameri Black, White ec <i>ify:</i> wh	etc.	
Maryland 21215-0036	vithin 72 hounders hen "neture	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	grade completed, College (1-4or 5+)	(Give life.	dent's Usua kind of wor DO NOT us	rk done d se retired,	tu <i>ring</i> most)	t of working	9	New Y	ork Ci	ty	
and 5	id be filed v ental Hygle kad other t ic event, III	To Be Co	17. Father's Name (First, Middle, La Isador			School	ol Tea	acne	18. Mothe		(First, Middle,	Maiden Sur	c Scho	OIS	
Mary	d 2 shou th and M 7 ie mar traumati	-	19a. Informant's Name/Relationshi Stephen Brickel				-				Route Numbe Ken si r	-	_	0895	
nore,	ages 1 an nt of Heal nt filtem 2 r or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Special Contro	B □Removal from		Place of Dispo cemetery, crei ean Mei	sition (Nan matory or o	ne of ther place	9)	Da	ite	20c. Locati	on - City or T	own, State	
Baltimore,	permit. P. Departme Important eny injury		21. Signature of Figure 1 Serv		— pad	T	2. Name an	d Addres	s of Facilit	ew Fu	neral	Home	-		
			23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that nly one cause on	caused the deat	h. Do not ent	er the mod	rrol e of dying	1 St. g, such as	cardiac or	wash:	ington rrest,	, DC	Approxim Interval B Onset and	etween
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		bral Va (or as a consec		Acci	dent							
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	(or as a consec	uanna of):									
,092	ate be executed hysicien and the burial-transit	I Examiner	Cause (Disease or injury that initialed events resulting in death) Last	c. Due to	(or as a consec	juence of);									
687	physic	dical		d											
.O. Box 6	The law requires that the death certifica ate has been signed by tha attending ph page 2 should be deteched for use as it	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12-months? 1 □ Yes 24□ No 9 □ Unknown	1 ☐ Live	utcome of pregnation birth 2 Fetalinant at time of conown	death 3	∃Ectopic pr ∃ Other (sp					23d.	Date of delive	ery Day	Year
S, D	uires that the signed by the signed by the detection is a signed by the		Part II. Other significant condition Hypertension	s contributing to	death but not res	sulting in the u	nderlying c	ause give	en in Part I.			obacco use o			
Vital Record	ding Physician: The law requir h. Atter this certificate has been si funeral director, page 2 should	Completed					-				24a. Was auto perfo	osy irmed?	4b. Were aut prior to c death? 1 \square Yes	opsy finding ompletion of 2 No	s available cause of
ital		BeC	25. Was case referred to medical						26. Place	of Death	Check only				
Ž	hysic his ce il dire	To	examiner? 1 ☐ Yes 2 ₹☐ No		Inpatient 2				4 🗆 NU		e 5 Resi				
iono	Attending Physician: r death. ector: After this certific by the funeral director.		27. Manner of Death 1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigs		of Injury nth, Day Year)	28b. Time o Injury	f 2	8c. Injury Work 1 □ `	vat ∢? Yes 2□		8d. Describe	how injury oc	curred	Н	ouse
Division of	al or Atte s after des st Directo	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	289. Plac	e of Injury - At h ding, etc. (Speci		reet, factory	, office		28	8f. Location (City or To		umber or Rui	al Route Nu	ımber,
	To the Hospital or Attendi within 24 hours after death. To the Funerel Director; A completely filled in by the fu	edical	29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the xaminer: On the and ma	ne best of my kno basis of examina nner stated.	owledge, deat ation and/or in	h occurred ivestigation	at the tim , in my or	ne, date an pinion, dea	nd place, ar ith occurre	nd due to the d at the time,	cause(s) and date and pla	d manner as ce, and due	stated. to the cause	o(s)
		×	29b. Signature and title of certifier Cynthia	mix	alli-				number	022	2		gned (Month Jer Z		
7	10		30. Name and address of person w	no completed car	use of death (Ite	m 23a) (Type,	Print)				•				0
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)		Ragistrar's Sign					,		,			
	negist	r ell	001 20		Marie Contraction	- 7									

DHMH 17 Rev 1/2001

		4	For State					artment of I	Health a		ental Hyg	2111)6	35463
			Registrar 1. Decedent's Name (File	ret Middle	act)		Cei	illicate of	Dealii		2. Date of Dea	og. 140.		3. Time of Death
	Physicia		Edmond	Juni		ittinge	r				Month Oct. 26	Day	Year	4:29 A M
	/Medic		4a. Facility Name (If not				1	4b. City, Town,	or Location of		OCC. 20	4c. County	of Death	
4	Examin	er	Garrett Co				al		aklan			Ge	arret	:t
	Funeral		5. Social Security Numb		. Sex	7. Age (In yrs.		If Under 1 Year		24 Hrs.	8. Date of Birth (Month, Day	Year)	9. Birth	place (State or Foreign intry)
1	Director		220-34-1562	2	1 X) M 2□ F	70	Yrs.	Months Days	Hours	MIII,	Apr. 25	, 1936	Mary	/land
	D.	-	Usual Residence of Dec			100 Cib	, Town or Lo	antion						10d. Inside City Limits
	ehov			b. County		100. 010		ountain	Talea T	01-				1 X Yes 2 □ No
	Ba-1	ecto	MD 10e. Street and Number		rrett		I'.	10f. Zip Code	Lake 1	Park		Og. Citizen of V	What Col	intry?
	with t	ā			vid			215	50				JSA	
	eafh	Funeral Director	602 Pensing	ger br		edent Ever in U.	S. 13.			gin? (Spec	ify Yes or No-			ican Indian,
	ter d	F	1 Never Married	2□ Married	Armed Fo	rces? 2 X No	į.	Was Decedent of f Yes, specify Cul			lican, etc.)	Blac	ck, White	, etc.
99	urs a	Ď	3 ☐ Widowed 4 🛚	_	If Yes, Gir Year or D	/e		1 ☐ Yes 2 🂢 No	Specify:			Specify	r: 1	White
ŏ	2 ho	ted	15.	Decedent's	Education grade completed)		16a. Dece	dent's Usual Occu	pation	t of workin	a	16b. Kind of Bu	ısiness/lr	ndustry
2	thin 7	nple	Elementary/Secondar		College (1-4or 5+)	life.	DO NOT use retir	ed)					
21	ygien ygien yer th	Completed	7				La	borer	40 14-4		(First Adiddle			ction
nd	tal H d oth	Be	17. Father's Name (Firs			~ ~ ~				irs Name i Ina		Maiden Suman	lend	
Z	1 Mer narke	၉	Jessie 19a. Informant's Name	J.	Bittin	ger	10b Maili	ng Address (Stree			Mae Poute Numbe			in Code)
Baltimore, Maryland 21215-0036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mential Hygiene. Item 27 ie marked other than "naturel", or itema 23a or 28a-f show other traumatic event, the Medical Exeminar must be notified at		Nancy M. 1			er								MD 21520
ည်	permit. Pages 1 and 2 Department of Health a Important: if Item 27 li eny injury or other tra		20a. Method of Disposit	-	,	20b. F	lace of Dispo	sition (Name of		Da	-	20c. Location -		
2	ages onfof t: If It y or c		1 X Burial 2 □ Cl 4 □ Donation 5 □			State		natory`or other pl c Fam11y		10/28	3/06	Swanto	n. M	D
	artme ortan injur		21. Signature of Funera					2. Name and Add				Second		
Ã	Depar Depar Impo		1 Bie	Den	Latter		S	tewart F	uneral	Home	0akla	and, MD	215	550
	-6-		23a. Part1. Enter the d shock, or heart fa	lisease, or co	omplications that	caused the deat	n. Do not en	er the mode of dy	ing, such as	cardiac or	respiratory arr	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition					ntracere					1	Onset and Death 4 Days
. Sec.	/Medical		resulting in death)	-	a	(or as a conseq								
*	Examiner		Sequentially list conditi	ions,	b									
	pe sit	Examiner	ri any, leading to imme- cause. Enter Underlyin Cause (Disease or inju-	diale	Due to	(or as a cunseq	ивпов сту.							
_	and and Il-tran	хап	that initiated events resulting in death) Last		c. Due to	(or as a conseq	uence of):			_			-	
760,	e be executed /sician and e burial-transit	calE												
687	- × e	edic			a.			Marakatan da kata a tarak kata a						
Box	leath certificate attending phy I for use as the	N	IF FEMALE: 23b. Was decedent pre	egnant		tcome of pregna		75-4				23d. Da	te of deliv	very
	death e atte	icia	in the past 12 mor		4□Preg	oirth 2 ☐ Feta nant at time of d		□Ectopic pregnan □ Other (specify)	су			Mo	onth	Day Year
P.0	at fhe de by the a	Physician/M	9 Unknown		9□ Unkr	IOWII								
	es tha	ğ	Part If. Other significan	nt condition	s contributing to c	leath but not res	ulting in the L	nderlying cause g	iven in Part I		1			the cause of death?
Records,	w requir been si should										1 1 4	es 2∭No	3 Pro	bably 4 Unknown
ec	elawr has be ge 2 sh	Completed									24a. Was a autop	SV	prior to co	topsy findings available ompletion of cause of
= H		S									1 ☐ Yes		death?	2 No
Vital	sician: T certificaf rector, pa	Be	25. Was case referred examiner?	to medical	Hospital: _ ع				26. Place	e of Death	(Check only o	ne)		
of	Physician: this certific ral director,	2	1 ☐ Yes 2 📉 No 27. Manner of Death		1 (2)		ER/Outpatie	IL 3LI DOA	4 🗆 191			ence 6 Oth		ufy)
E	Jing I J. After funer	0	1 X Natural 5	Pending		oth, Day Year)	Injury	W	ork? ⊒Yes 2. □		od. Describe ii	Owningury occur	100	
Division	Attending r death. ector: After by the funer	fica		Could no	t be 390 Plac	e of Injury - At h	ome, farm, st	reet, factory, office			8f. Location (S	treet and Numb	per or Ru	ral Route Number,
Div	after after Dire	Certification;	4 Homicide	determin		ling, etc. (Specii		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			City or Tow	n, State)		
	Hospital or the hours afte Funeral Dir tely filled in I		29a. Certifier 1X	Certifying	Physician: To th	e best of my kno	wiedge, dea	h occurred at the	time, date ar	nd place, a	nd due to the d	cause(s) and ma	anner as	stated.
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	one)		xaminer: On the l	ner stated.	mon and/or if							
	To the vithin 2 To the comple	Σ	29b. Signature and title	of certifie					nse number			29d. Date signe	•	
			1	X					23979			10)/27/	00
		1	30. Name and a dress Dr. Robe	- 1				Print)	Oal-	land	MT) 21	.550		
-73	4 0	ate	31. Date filed (Month,			Registrar's Signa		uren be	, oak	rana,	ا ک سند			
	Regist		^	CT 3	1 2006	Agentines .		Janually 19						
						The state of the s	2008	1						

		For State Registrar	tate of Marylar		artment of H tificate of L			giene 0	06	35464
		Decedent's Name (First, Middle, Last)					2. Date of Dea		V	3. Time of Death
Physici /Medi		Joseph A.	Buebe				October	Day 20, 20	006	1:58 A M
Examir		4a. Facility Name (If not institution, give street	et and number)		4b. City, Town, or	Location of Deat	h	4c. Count	ty of Death	
•	ĝ.	Prince George's Hos	pital Cente	r	Chever1	у		Princ	ce Geo	rge's
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		h v Year)	9. Birthp	lace (State or Foreign
Director	^	110-20-5390 ^{¹™™}	^{2□ F} 79	Yrs.	World bays	TIOUIS IVIII.	Nov. 5	, 1926	New	York
D >		Usual Residence of Decedent 10a. State 10b. County	10a C	ity, Town or Lo	antion					Od Inside Oits Limite
aryla shov	-				CallOff				'	0d. Inside City Limits 1 ☐ Yes 2 🛣 No
8a-f-	Director	Virginia Fairfax	But	rke						
vith ti		10e. Street and Number			10f. Zip Code			10g. Citizen of		
s 23	rai	5258 Queens Wood Dri	LVE Was Decedent Ever in t	10 101	22015	. 0	1 1/ N	United		
ler de Item	Funerai	Tr. Walter States	Armed Forces?	1	Vas Decedent of Hi f Yes, specify Cubai	spanic Origin? (S n, Mexican, Puerl	to Rican, etc.)		ice - Americ ack, White,	
Irs af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	948-	☐ Yes 2X No	Specify:		Speci	whi	te
(1215-50036) within 72 hours after death with the Maryland ene. then "neturel", or Items 23e or 28e-f show the Maryland Expringent most be rectified at	ed	15. Decedent's Educati	on .	16a. Deced	lent's Usual Occupa	ation		16b. Kind of E		
0 7 nu	Completed	(Specify only highest grade co		(Give	kind of work done d DO NOT use retired,	lurina most of wor	rking	United		,
The mit	ē	Elementary/decordary (0-12)	College (1-4or 5+)	Majo	r / Pilot			Air Fo	rce	
of Hys	Bec	17. Father's Name (First, Middle, Last)					me (First, Middle,	Maiden Suma	me)	
ITYIBIG Z1Z15-UU36 should be filed within 72 hours after death with the Marylan ad Mental Hygiene, marked other than "neturel", or Items 23e or 28a-f show imatic event, the Medical Examinar Inval be redified at	5 B	Anthony F. Buebe				Marie H	elen Lou	р		
		19a. Informant's Name/Relationship (Type,	Print)	19b. Mailin	g Address (Street a	and Number or Ru	ural Route Numbe	ar, City or Town	ı, State, Zip	Code)
		Winifred Buebe / Wi	fe	5258	Queens Wo	ood Driv	e, Burke	, VA 22	2015	
		20a. Method of Disposition	1	Place of Dispo- cemetery, cren	sition (Name of natory or other place	9)	Date	20c. Location	- City or To	wn, State
baltimor permit. Pages Department of Importent: If it any injury or o		1 M Burial 2 ☐ Cremation 3 M Remarks 4 ☐ Donation 5 ☐ Other (Specify)		lington	Nat. Cem	1. 12/2	2/2006	Arlingt	on. V	irginia
Department Importent: I my injury o		21. Signature of Funeral Service Lifensee			Name and Addres					
D-188 - 8		In & / war	M00956	9	902 Bradd	lock Road	d, Fairf	ax, VA	22032	
		23a. Part1. Enter the disease, or complicati shock, or heart failure. List only one c	ons that caused the dea							Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Sepsis						1	Onset and Death Day
/Medical		resulting in death)	Due to (or as a conse	quence of):						Day
Examiner		No. of the Control of								
	ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	quence of):						, - · ·
cutec nd ransl	Examiner	Cause (Disease or injury that initiated events								
e exe	EX	resulting in death) Last	Due to (or as a conse	quence of):						
Hecords, P.O. Box 68/60, The law requires that the death certificate be executed the has been signed by the attending physician and oage 2 should be detached for use as the burial: transit	edicai	d.							-	
rtiffice ng ph	Med	IF FEMALE:								
BOX 6 eath certific attending p	Physician/M	23b. Was decedent pregnant 23c.	If yes, outcome of pregn 1□Live birth 2□Fet	ancy al death 3□	Ectopic pregnancy				ate of delive	
D. E e dea he at ed fo	sici	I LI THS Z LINO	4☐ Pregnant at time of 9☐ Unknown		Other (specify)			M	onth	Day Year
that the de	Phy	9 Onknown								
igned	ρ	Part II. Other significant conditions contrib		_						e cause of death?
w require	Completed	Chronic Obstructive	Lung Diseas	se, Kes	piratory	Failure,	1 🔼 Y	′es 2 □ No	3 Prob	ably 4 □Unknown
as be	ple	Ventilator Dependent					24a. Was autop	an 24b.	Were autor	osy findings available inpletion of cause of
	Ю						perfo	rmed? 2 No	death? 1 ☐ Yes	
VICAL HECOTOS, reiclan: The law requires to certificate has been signed inector, page 2 should be to	Be (25. Was case referred to medical examiner?				26. Place of Dea	ath (Check only o			
Of VITA Physician: this certific ral director,	P	1 ☐ Yes 2 No	ital: 1 ☐ Inpatient 2🛭	ER/Outpatien	t 3 DOA Othe	ar: 4 🗌 Nursing H	lome 5 ☐ Resid	tence 6 🗆 Ot	her (Specify)
⊆ 20 a a a a		27. Manner of Death 1 Matural 5 Pending	8a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at ?	28d. Describe h	now injury occu	rred	
DIVISION (But or Attending is after death. I Director: After din by the funer.	Certification:	2 Accident investigation				fes 2 □No				
Y A Line	Ę	3 Suicide 6 Could not be determined	 Place of Injury - At h building, etc. (Special 	nome, farm, stre ify)	eet, factory, office		28f. Location (S City or Tow	Street and Num in, State)	ber or Rura	Route Number,
spital or cours afte neral Dir filled in										
To the Hospital of within 24 hours at To the Funeral D completely filled in	edical	(Check only 2 Medical Examiner:	on: To the best of my kn On the basis of examin	owledge, death ation and/or inv	occurred at the tim	e, date and place pinion, death occu	, and due to the our	cause(s) and m	anner as sta	ated. the cause(s)
the Hos hin 24 ho the Fun npletely	Med	onej	and manner stated.							
To with	~	29b. Signature and title of certifier	0 1.	1.	29e, License			29d. Date signe	ed (Month, L	Jay, Year)
1+1		Kanll	ull	In		1852		October	22,	2006
-		30. Name and address of person who comp						0.00		
and the second		Paul A. Devore, M.D.			Road, Hy	attsvil	Le, MD 2	0781		
Sta Regist	ate rar	31. Date filed (Month, Day, Year) OCT 2 4 2006	32 Registrar's Sign	A Asia	est of					

DHMH 17 Rev 1/2001

			For State Registrar		State c	ır maryı			tment of H ificate of I	lealth and N <i>Death</i>	nental Hy	/gien Reg. N	ZUUI	6	35465
	Physici /Medio		1. Decedent's Nam M U 12	e (First, Middle, L.	ast)	BAIL	-EV				2. Date of De Month	eath Da	-		3. Time of Death
0	Examir		4a. Facility Name (I			m <i>ber</i>)			4b. City, Town, or	r Location of Death		40	. County of D		
			SUBUR 5. Social Security N	BAN HOSPITA	AL	7 Ann (In	usa laat bist		If Under 1 Year	BETHESDA If Under 24 Hrs.	T		MONTGOM		
	Funeral Director		235-42-0	844	1□M 2⊠F		yrs. last birth 80 Y	rs.	Months Days	Hours Min.	8. Date of Bi (Month, Da MARCH 04	ay, Year	9. 26 WE		ce (State or Foreign y) IRGINIA
	yland		10a. State	10b. County		10c.	. City, Town	or Loca	ation		<u></u>			100	d. Inside City Limits
	e Mar	Director	MARYLAND	MONTGOM	ERY		SI	LVER	SPRING						1 ☐ Yes 2 🖫 No
	with th	Dire	10e. Street and Nu						10f. Zip Code			10g. C	itizen of What	Countr	y?
	eeth v	eral	2149 ED	GEWARE STRI	EET 12. Was Dec	adent Ever i	2110	12 14)905			U.S.		. In all .
36	s 1 and 2 should be filed within 72 hours after deeth with the Maryland F Health and Mental Hygiene. It Health and Mental Hygiene. Items 27 ie marked other than "natural", or itams 23e or 28e-f ehow other traumatic event, the Madical Examinar must be notified at	by Funeral		ied 2 ☐ Married	Armed For 1 Tes, Gir Year or D	orces? 2 ∰ No ve	11 0.3.		as Decedent of Hi Yes, specify Cuba ☐ Yes 2 1 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	0-	14. Race - A Black, W Specify:	hite, et	
9-0	72 hou	ted	(Cons	15. Decedent's E	ducation		16a. I	Decede	nt's Usual Occupa	ation		16b. i	Kind of Busine		
Maryland 21215-0036	ithin 7 ne. nen "n	Completed	Elementary/Seco	ondary (0-12)	College (1-4or 5+)		life. D	nd of work done of O NOT use retired	during most of work 1)	cin g				•
2	2 should be filed within and Menta Hygiene. Is marked other than aumatic event, the Manault event, the Manault event, the Manault event, the Manault event, the Manault event, the Manault event, the Manault event, the Manault event, the Manault event, the Manault event, the Manault event, the Manault event, the Manault even		9 17. Father's Name	/Einst Middle Las	*1			Н	OME MAKER	40 14-4	- /5 14:14		OWN H	OME	
and	d be f	o Be		MILLER	.,					18. Mother's Nam		, маю	n Sumame)		
Z Z	should nd Men marke umatic	2	19a. Informant's Na		(Type, Print)		19b.	Mailing	Address (Street a	and Number or Rui	A YEAGER al Route Numb	er. City	or Town. State	e. Zio C	ode)
Š	and 2 Balth a n 27 le		LENNIA I	KLING - DAT	JGHTER					STREET, SII					
Baltimore,	of He		20a. Method of Disp	position Cremation 3 [Bamoval from		b. Place of I	Disposi	tion (Name of atory or other plac		Date		ocation - City		
ĄĒ	tment of I tant: If It ijury or o		4 Donation	5 Other (Spec	ify)	State	PARKLAV	-	EMORIAL PAI	The second secon	4/2006		KVILLE,	MARY	LAND
Ba	permit. Peges 1 and 2 Depertment of Health a important: if Item 27 is any injury or other tra once.		21. Signature of Fu	yehn T	Plob	erf		22. H 1	Name and Addres INES-RINAL 1800 NEW H	ss of Facility DI FUNERAL IAMPSHIRE AV	HOME, IN VENUE, SI	C. LVER	SPRING.	MARY	/LAND 20904
0	Physician pe executed be executed by Madical Examiner desthe purial-transit	Examiner	shock, or hea Immediate Cause of condition resulting in death) Sequentially list condition of any learning to improve cause. Enter Unde Cause (Disease or that initiated events resulting in death) in	nditions, and distinct on the control of the contro	a. Due to	(or as a con	sequence of):		g, such as cardiac				le le	oproximate Interval Between Onset and Death Conset and Death
3 fm 3 fm s, P.O. Box 68760,	The law requires that the death certificate be executed te has been signed by the ettending physicien and age 2 should be detached for use es the burial-transit	Completed by Physician/Medical	IF FEMALE: 23b. Was deceden in the past 12 1 □ Yes 2 □ 9 □ Unknown Part II. Other signif	months?	4□Pregr 9□ Unkn	oirth 2 🗍 F nant at time own	etal death of death	5 🗆 (ctopic pregnancy Other (specify) erlying cause give		23e. Did	tobacco	23d. Date of Month	Ď	ay Year
/ene	v require been si should b	ted	Hype	1 Cal ce	MIA						1/4	Yes 2	!□No 3□	Probab	ly 4 □Unknown
× Occ		Comple									24a. Was auto perfo 1 Yes		prior	to comp	y findings available pletion of cause of
γp_{cc} Vital	Physicien: Th this certificete ral director, pag	Be	25. Was case refer examiner?	•	Hospital:				2□ DOA Othe	26. Place of Deat					
100	Phys or this oral di	7: To	1 ☐ Yes 2 ☐ 27. Manner of Deat		10	npatient a of Injury th, Day Year	2 ER/Outp 28b. Ti		3 DOA	4 🗆 Nursing Ho	me 5 Resi			pecify)	
30.0	ending feath. or: After he funer	atlo	1 Accident	5 Pending investigation		th, Day Yea	r) Inj	ury	28c. Injury Work M 1 □ `	k? Yes 2 □No			.,		
5/2/ Divisi	el or Atte s after de il Directo id in by th	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not I determined	289. Place	of Injury · Aing, etc. (Sp	At home, fart ecify)	n, stree	t, factory, office		28f. Location (City or To	Street a wn, Stat	nd Number or e)	Rural F	Route Number,
Ø,	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical (29a. Certifier (Check only one)	1 Certifying P 2 Medical Exa	miner: On the b	best of my asis of exam ner stated.	knowledge, nination and	death o	occurred at the time stigation, in my op	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s	s) and manner d place, and c	as state	ed. ne cause(s)
	To the vithile comp	Ň	29b. Signature and	title of certifier					29c. License			29d. Da	ate signed (Mo	onth, Da	y, Year)
	10		1	スラ	1				729	1675		00	420,	20	06
_			30 Name and addr	V. Bocc	ity m.	2 6	Item 23a) (T	ype, Pr			Bet	7265	420, h	1D	
	Sta Registr		31. Date filed (Mon		2006	legistrar's Si	gnature	Goo	de	0		.0			

			1 - For State Registrar	State of M	Maryland	•	artment rtificate			and Me		jiene.		354	66
			1. Decedent's Name (First, Middle,	Last)							2. Date of Dea Month	th Day	Yea	3. Time o	of Death
	Physici /Medic		Edna Phyllis Br	ackett Bra	dley_						ctober			5:45	A ^M
	Examin		4a. Facility Name (If not institution,	-	er)		4b. City,	Town, or	Location o	of Death		4c.	County of De		
			23520 Shiloh Ch			- 4 5 7-45 4 3	If Under	Boyo	1s If Under 3	24 Hrs	0 D-1 -4 D-1			gomery	
	Funeral		5. Social Security Number 441-30-2231	6. Sex 7 1 ☐ M 2 ☑ F	Age (In yrs. la 78	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day Feb. 2]	Year)	28 01	Birthplace (State Country) klahoma	or r-oreign
	Director		Usual Residence of Decedent		70						reb. Zi	., 1)	20 01	CIAHOMA	
	yland		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside C	ity Limits
	Mar-fish	tor	Maryland Montg	omery		Boyds								1 🗌 Yes	2 ⊠ No
	or 28	Funeral Director	10e. Street and Number				10f. Zip	Code				10g. Citiz	zen of What	Country?	
	23a	la [23520 Shiloh Ch						841					States	
	tems	nne	11. Marital Status	12. Was Decede Armed Force	s?	S. 13. \	Vas Deced f Yes, spec	ent of History of Cubar	spanic Oriç n, Mexican	gin? (Spec , Puerto R	city Yes or No- lican, etc.)	1	14. Race - Ar Black, W	mencan Indian, hite, etc.	
36	rs afte	by F	1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 ☐ Yes 2 € If Yes, Give Year or Date:			1 🗌 Yes 2	No No	Specify:				Specify:	White	
21215-0036	within 72 hours after death with the Maryland ene. than "neturel", or items 23e or 28e-f show the Madical Examiner must be notilled at	ed	15. Decedent	s Education		16a. Deced	ient's Usua	l Occupa	ition			16b. Kir	nd of Busine	ss/Industry	
215	nin 72 n "nu Mad	Completed	(Specify only highest Elementary/Secondary (0-12)	completed) College (1-4c	or 5+)	(Give life. L	kind of wor DO NDT us	rk done d e retired)	lu <i>ring</i> most)	of workin	9				
217	d with	E O	Listing iteration (5 int)	4		Homer	naker					C	wn Hor	ne	
pg	be file tal Hy d oth	Be (17. Father's Name (First, Middle, L								(First, Middle,				
yla	Meni Meni Marke	၉	Willie Tyne Bra								Aileen				
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heelih and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic avent, the Madical Examinat must be notified at once.	13	19a. Informant's Name/Relationsh		1 1		-				Route Numbe				
e,	1 and Heeltl am 27 than t		Russell Glenn Br 20a. Method of Disposition	adley / Hus		ace of Dispo			T	Da	, Boyd			or Town, State	
Jon L	nt of nt of t: If it		1 ☐ Burial 2 ☑ Cremation		te ce	metery, cren	natory or ot	ther place			er 23,				. 1
ᄩ	entme entme ortani injury	1	4 Donation 5 Other (Sp 21. Signature of Euneral Service 1		Res	sthave				200				k, Maryl	
Ba	Depermination of the suppose of the	5 5	15/16											ody P.A. MD 21701	
			23a Part Enter the disease, of shock, or heart failure. List of	complications that caus	sed the death								zon,	Approxima Interval Be	te
E	Physician		Immediate Cause (Final disease or condition			Shock								Onset and	
	/Medical		resulting in death) Due to (or as a consequence of):												
	Examiner		Sequentially list conditions	b. Acute	Myocar	dial	Infar	ct						- Control of the Cont	
	D #	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Atherosclerotic Heart Disease Due to (or as a consequence of):													
	and and I-trans	хаш	that initiated events resulting in death) Last	U	sclero		eart l	Disea	ase					 	
8760,	icate be executed physicien and s the burial-transit														
687	ficate physics the	Physician/Medical		d											
Вох	death certific e attending p id for use as i	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			ie					2	3d. Date of o	telivery	
	death e atte	Cla	in the past 12 months? 1 □ Yes 2 ☒No		at time of de		JEctopic pre Other (spe						Month	Day	Year
О		hys	9 🗆 Unknown	9□ Unknown							T				
	8 20	by	Part II. Other significant condition		but not resu	Iting in the ur	nderlying ca	ause give	n in Part I.		_			to the cause of	
ord	w require been sig should b	ted	Congestive Hear	t Failure							1UY	es 215	§No 3∐	Probably 4 🗌	Unknown
Vital Records,	\$ C C	Completed									24a. Was a autops	SV	prior t	autopsy findings o completion of c	available cause of
<u> </u>	Th ete pag	S									perfor	med? 2 <u>₩</u> No	death 1 🗆 Y	es 2□No	
Vita	lcian Sertifi ector	Be	25. Was case referred to medical examiner?	Hospital:				Otho			Check only or				
o	Physician: this certific ral director.	<u>۱</u>	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 ☐ Inpa	atient 2 E	ER/Outpatien 28b. Time of			4 🗀 1401		e 5 🖾 Reside			pecify)	
	ding h. After funer	28a. Date of Injury (Month, Day Year) 28b. Time of Injury Nork? 28c. Injury at Work? 1 Nork? 1 Nork? 2 Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)									33. D0301100 11	J. W. 111, U. Y	33041133		
Division	Attan deat ctor: y the	1ca	3 Suicide 6 Could n	ot be 28e. Place of			et, factory,				8f. Location (S	treet and	Number or	Rural Route Nun	nber,
á	s after	Sert	4 Homicide	building,	etc. (Specify,)					City or Tow	n, State)			
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical ((Check only 2 Medical E	Physicien: To the be xaminer: On the basis	of examinati										s)
	thin 2 the mplet	Med	29b. Signature and title of certifier	and manner	stated.		29c	. License	number			9d. Date	signed (Mo	nth, Day, Year)	
)	£318			16				478						, 2006	
	1	ŀ	30. Name and address of person v	no completed cause o	f death (Item	23a) (Type									
	`		Oney Zuniga, M.	.D. 4701 Ra	ndo1ph	Road	, Ste	. 21	6, Ro	ckvi	lle, MD	208	352		
	Sta		31 Date filed (Month, Day, Year)	32. B	strar's Signat	ure	have:	,							
	Registr	ar	OCT 2	3 ZUUD	wer.	No Ki									

			For State of Maryla	•			-	2000	25167
			Registrar	Cei	rtificate of De		Reg. i	No2006	
	Physici	an	1. Decedent's Name (First, Middle, Last) James Biggs				Month I	Day Year	3. Time of Death
	/Medic		James Biggs 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Lo		October	27, 200 4c. County of Deat	
	Examin	er	5767 Mt. Herman Church Ro	na d	Salisbu			Wicomi	
_	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs	. last birthday)	If Under 1 Year If	Under 24 Hrs.	8. Date of Birth	Q Rint	holace (State or Foreign
	Director		220-80-3000 X□M 2□F 89	Yrs.	Months Days I	Hours Min.	Month, Day, Ye.	1916 Wic	omico
	D .		Usual Residence of Decedent 10a. State 10b. County 10c. C	ity, Town or Lo	estion			-	10d. Inside City Limits
	ehov	ក	MD Wicomico						1 ☐ Yes 2 € No
	28a-1	Director	10e. Street and Number	Salis	10f. Zip Code		100	Citizen of What Co	
	with 3s or		5767 Mt. Herman Church Ro	ad	21804			ited Sta	
	death with the Maryland me 23a or 28a-f ehow rmust be notified at	Funerai	11 Marital Status 12. Was Decedent Ever in		Was Decedent of Hispa If Yes, specify Cuban, I	anic Origin? (Spec		14. Race - Ame	rican Indian,
٥	or its		Armed Forces? 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes, Give		_	mexican, Pueno H Specify:	ucan, etc.)	Black, White	
21215-0036	hours after turel', or its at Examine	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:					0.57	
7	"net	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupation kind of work done duri DO NOT use retired)	n ing most of workin	g 16b	. Kind of Business/	Industry
7	within 72 ene. then "net	Ĕ	Elementary/Secondary (0-12) College (1-4or 5+)		embler			wer Shore	e Enterprises
	be filed within 72 hours after death with the Marylan ital Hygliene. Id other then "neturel", or iteme 23s or 28s-f ehow event, the Madical Examiner must be notified at	a)	17. Father's Name (First, Middle, Last)		18	3. Mother's Name	(First, Middle, Maid	den Surname)	
and		To B	Joseph Biggs			Emma Co	ordrey		
Mary	d 2 should th and Men ?7 le marke traumatic		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and	Number or Rural	Route Number, Cit	ty or Town, State, 2	^{Zip Code)} 21804
_	s 1 and 2 if Health item 27 other tra		Gladys Warrington/Companion	2/0/	Mt. Heri	man Chu	rch Kd.	salis	bury, MD
9	Pages 1 nent of H int: If ite		tyGeBurial 2 ☐ Cremation 3 ☐ Removal from State _	cemetery, crer	sition (Name of natory or other place)			. Location - City or	
Baitimore,	tment tent:		4 □Donation 5 □Other (Specify) Sp		1 Mem. Gar			oron, Mar	
g	permit. Pages Department of i Important: If iti eny injury or o onca.		21. Signature of Funeral Service Licensee Without 7 - 9 km	21	Name and Address of N. Main	St., Fed	iptom Fu eralsburg	neral H g, MD 216	ome, P.A. 32
			23a. Part1. Enter the disease, or complications that caused the deshock, or heart failure. List only one cause on each line.	ath. Do not ent	er the mode of dying, s	such as cardiac or	respiratory arrest,		Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	piratio	in preu	monia			Onset and Death
	/Medical Examiner		immediate Cause (Final disease or condition resulting in death) Due to (or as a consecution as a consecutio	quence of):	,	¥			
		70	Sequentially list conditions, if any, leading to immediate Due to (or as a conse	Sinus	Sundran	n.e.			
	t Insit	Examine	Cause. Enter Underlying Cause (Disease or injury		1.60				
'n	the death certificate be executed y the ettending physician and Iched for use as the bunal-transit		that initiated events c. resulting in death) Last C. Due to (or as a conse	quence of):					
8/eU	nte be nysicia ne bu	dicai	d						
٥	ntifica ing pr	0	IF FEMALE:						
ž Q	eath certific ettending p i for use as l	Physician/M	23b. Was decedent pregnant 1 Live birth 2 Fe	tal death 3	Ectopic pregnancy			23d. Date of del Month	ivery Day Year
- -	at the de by the e tached f	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of 9 ☐ Unknown	death 5	Other (specify)				,
J.	res thet ti igned by be detac	/Ph	Part II. Other significant conditions contributing to death but not re	sulting in the u	nderlying cause given i	in Part I.	23e. Did tobaco	co use contribute to	the cause of death?
B	sign sign ld be	d by					1 ☐ Yes	2 No 3 Pr	obably 4 Unknown
Vital Records,	The law requires thet ite has been signed b bage 2 should be deta	Completed					24a. Was an	24b. Were au	itopsy findings available completion of cause of
Ë	The law cate has page 2:	E					autopsy performed 1 ☐ Yes 2 ☑	2 death?	completion of cause of
E		BeC	25. Was case referred to medical		20	6. Place of Death		140 11163	2010
	hysic this ce al direc	70 1		☐ ER/Outpatier	at 3 DOA Other:	4 Nursing Hom	e 5 Aesidence	6 □Other (Spec	cify)
Ĕ	ing Ph After th uneral	ino :	27. Mann of Death 1 Natural 5 □ Pending 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work?		Bd. Describe how in	njury occurred	
<u>s</u>	Attending P death. ctor: After i y the funera	icat	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At	home form str		s 2 □No	8f. Location (Street	t and Number or O	red Poute Number
DIVISION OF	after d after d Direct d in by t	Certification;	4 Homicide determined building, etc. (Spec	cify)	eet, ractory, office		City or Town, St	tate)	irai moute ivumber,
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my kr 2 Medical Examiner: On the basis of examinand manner stated.	nowledge, deat nation and/or in	h occurred at the time, vestigation, in my opini	date and place, a ion, death occurre	nd due to the cause d at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	ro the vithin o the omple	Me	29b. Signature and title of codifier		29c. License n	umber	29d.	Date signed (Monti	h, Day, Year)
)	->-0) mn		054	127		11/1/0	06
			30. Name and address of person who completed cause of death (Ite	am 23a) (Type.	Print)	· h	mo z	1804	/
	Sta	te		nature	4/115	7	2	1007	
	Registr		31. Date filed (Month, Day, Year) 32" Registrar's Sign	J. 600	weer -				

			Please	Type or Print State of Mar	in Black Ir vland / Dep	adelible Ink. partment of H	ealth and Men	tal Hygien	2006	35468	
		1	For State Registrar		Ce	ertificate of L	eatn	Reg. N		O Time of Dooth	
			. Decedent's Name (First, Middle, Last)						ay Year	3. Time of Death	
	Physicia /Medic		Frederick Roland Bilbrough la. Fecility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			c. County of Deat	12:20 P M	
,	Examin									Caroline	
			25321 Smith Landi 5. Social Security Number 6. S	In yrs. last birthday	Denton y) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day.			9. Birthplace (State or Foreign			
	Funeral Director	1	13 1100	□M 2□F 84	Ven	Months Days	Months Days Hours Will		19, 1924 Maryland		
		-	210-12-1770							10d. Inside City Limits	
	s within 72 hours after deeth with free maryland siene. Than 'nature!', or iteme 23e or 28e-f show the Medical Examinar must be notified at	Funeral Director	10a. State 10b. County		Dent					1 ☐ Yes 2 € No	
			Manyland Can	oline	Dence	10f. Zip Code		10g. (Citizen of What Co	ountry?	
			25321 Smith La	nding Roa	d	2162				s of America	
			11. Marital Status	12. Was Decedent Ev	12. Was Decedent Ever in U.S. 13.		. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)		No- 14. Race - American Indian, Black, White, etc. Specify: Coucousion.		
ဖ			1 ☐ Never Married 2 ☑ Married	12 Yes 2 No 7943-		1 ☐ Yes 2 ☑ No Specify:					
93		d b	3 Widowed 4 Divorced	Year or Dates:	Land Double Have Convention		ation	16b. Kind of Business/Industry			
15-(n 72 h	To Be Completed by	15. Decedent's Education (Specify only highest grade completed) Flamentary/Secondary (0-12) College (1-4or 5+)					st of working			
21215-0036	iit. Pages 1 end 2 should be filed ertment of Heelth end Mental Hyg ortant: If Item 27 te marked othe injury or other traumatic event, injury or other traumatic event,		Farman					Total Middle Mais	Agriculture		
פֿב			17. Fathers Name (First, Middle, Last)					First, Middle, Maiden Sumame)			
Maryland			Garfield Bilbrough Lyda Gree 19b. Mailing Address (Street and Number or Rura								
			19a. Informant's Name/Relationship Louise Ott Billsrough	Type, Print) Wife			ling Road, Den				
			20a. Method of Disposition		20h Place of Dis	sposition (Name of crematory or other pla	Date	200	Location - City o	r Town, State	
Baltimore			12 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Green shore Compteny 10/29/2006 Green shore, Carpenshore Compteny							Paryland	
İ			21. Signature Funeral Service Licensee 22. Name and Address of Facility Moone Funeral Home, P. A. 13 South Second Facility 12 South Second Facility 13 South Facility 13 South Facility 13 South Facility 13 South Facility 13 South Facility 13 South Facility 13 South Facility 13 South Facility 13 South Facility 13 South Facility 13 South Facility 13 South Facility 13 South Facility 13 Sou								
B	Ped in a									Approximate	
	Physician	Examiner	Interval Be						Interval Between Onset and Death		
,			Immediate Cause (Final disease or condition	pneu	monea			azys			
4	/Medical Examiner		Due to (or as a consequence of): /							years	
			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	b. Due to (or as a consequence of): Congestive heart failure Due to (or as a consequence of):					4	
	eath certificate be executed ettending physicien end for use as the burial-transit		cause. Enter Underlying Cause (Disease or injury that initiated events	coronary antery di				disea	sease years		
ó			resulting in death) Last	Due to (or as	Due to (or as a consequence of):						
68760,		Physician/Medical	d								
x 68		Mec	IF FEMALE:	23c. If yes, outcome	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)				23d. Date of d		
Box	ath etter for u	clan	23b. Was decedent pregnant in the past 12 months?	4 ☐ Pregnant at					Month Day Year		
P.O.	law requires thet the de as been signed by the e 2 should be deteched	hysic	1 Yes 2 No 9 Unknown						23e. Did tobacco use contribute to the cause of death?		
		by Pi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						1 Yes 2 No 3 Probably 4 Unknown		
		ted						24h Ware autonsy findings		autonsy findings available	
ecc	law relas be	ple						autopsy	autopsy prior to completion of cause of		
Division of Vital Records,	To the Hospital or Attending Physicien: The law within 24 hours effer death. To the Funcel Director: Affer this certificate has a completely filled in by the funeral director, page 2,	Completed	performed? death? 1 Yes 2 No 1 Yes 2 No No No Yes 2 No No No No No No No								
		Be	25. Was case referred to medical examiner?		Home 5 Residence 6 □Other (Specify)						
		Medical Certification: To	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Guist. 4 Nursing H				28d. Describe how injury occurred			
			1 Natural 5 Pending investigation	ion		M 1	Tyes 2□No	(0)		Dural Bouto Number	
visi			3 Suicide 6 Could no determin					City or Town,	(Street and Number or Rural Route Number, own, State)		
Ö	ital or irs efter rel Dir			Di isiaa Tarka baat	of my knowledge	death occurred at the	th occurred at the time, date and place, and due to the cause(s) and manner as stated.			as stated.	
	Hosp 4 hou Fune iely fil		29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only one) Contribution (Check only one) Contribution (Check only one) And manner stated.								
	thin 2 thin 2 the omple										
	290. Signature and time of samuely MD Doo4							10/26/06			
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)								
_			Wafik Zaki, M.D. 920 Market Street, Denton, Maryland 21629 31. Date filed (Month, Day, Year) 32. Registrar's Signature								
	Regis	tate	31. Date filed (Month, Day, Year)	2 17 7000 S	A Source	IN Apart	3.00				
	negis	لقالد			7						

DHMH 17 Rev 1/2001

December Same Price (March Land) December Same				1 - For State Registrar	State of Maryla		artment of H <i>tificate of l</i>			en e) () () 6	35469
Security As Service Security Assembly Securit	V.				ın Beaven						
This State Total Control		Examir Funeral		4a. Facility Name (If not institution, give st. Memorial Hospital 5. Social Security Number 6. Sex	reet and number) 7. Age (in yi		Easton If Under 1 Year	If Under 24 Hrs	8. Date of Birth	4c. County of Dea 7 allo 9. Bin	thplace (State or Foreign
Compact of Windows and Summary Control (State) Control (State)	47	D.	<u>.</u>	Usuaf Residence of Decedent 10a. State 10b. County		City, Town or Lo			ogaenwer	70,7710 110	10d. Inside City Limits
Specify Colf Proprietal grows completions College (1-4or 5-s) Homemorker Home		with the Mi a or 28a-f		10e. Street and Number	Posel	Cuscon	10f. Zip Code	1			ountry?
Specify Colf Proprietal grows completions College (1-4or 5-s) Homemorker Home	350	ırs after death il', or iteme 23 халтлаг лив	by Funera	11. Marital Status 12 1 Never Married 2 Married	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (S n, Mexican, Puer		14. Race - Ame Black, Whit	erican fndian, te, etc.
18 Mother's Name (First, Mother, Name (First, Name	JD-01717	within 72 hou iane. r than "neture the Medical E		(Specify only highest grade Elementary/Secondary (0-12)	completed)	(Give	kind of work done of DO NOT use retired	during most of wo	rking 1	6b. Kind of Business	
Distance Distance	ylandz	be filed tal Hyg d othe	Be	17. Father's Name (First, Middle, Last) Edward Coo,				18. Mother's Nar Ella La	owe Anthor	laiden Sumame) ny	
Secure Securi Security Secure Security Secure Security Security Security Security Security Security Security Security Security Security Security Security Security Security Secur	ге, маг	1 and 2 Health a em 27 is ther tra		William N. Beaven	Son	9373	Kingstor	n Landing	g Road, Ed	aston, Mar	yland 21601
Physician Medical Examiner Physician Medical Examiner By Date of the straining in death of the straining in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Morre audicing in the straining in the underlying cause given in Part I. 2 Straining in death of the straining in the underlying cause given in Part I. 2 Straining in death of the straining in the underlying cause given in Part I. 2 Straining in death of the straining in the underlying cause given in Part I. 2 Straining in death of the straining in the underlying cause given in Part I. 2 Straining in death of the straining in the underlying cause given in Part I. 2 Straining in the straining in the underlying cause given in Part I. 2 Straining in death of the straining in the underlying cause given in Part I. 2 Straining in death of the straining in the underlying cause given in Part I. 2 Straining in death of the straining in the underlying cause given in Part I. 2 Straining in	аппо	Page ent o nt: if ry or		4 ☐ Donation 5 ☐ Other (Specify)	Sa	t. Paul'	s Cemete	ry 10/20			
Sequentially list conditions, Tark, leading to smirediate Cause (in the cause of death?) Sequentially list conditions, Tark, leading to smirediate Cause (in the cause of death?) Sequentially list conditions, Tark, leading to smirediate Cause (in the cause of death?) Cause (in the cause of death?) Sequentially list conditions, Tark, leading to smirediate Cause (in the cause of death?) Local List indicated events are unity leading to smirediate cause of death? Sequentially list conditions, Tark, leading to smirediate Cause (in the cause of death?) Local List indicated events are unity leading to smirediate cause of death? Sequentially list conditions, Tark, leading to smirediate cause of death? Local List indicated events are unity leading to smirediate cause of death? Local List indicated events are unity leading to smirediate cause of death? Local List indicated events are unity leading to smirediate events are unity leading to smirediate events and the cause of death? Local List indicated events are unity leading to smirediate events are unit		Physician /Medical		shock, or heart failure. List only one fmmediate Cause (Final disease or condition	ations that caused the decause on each line.	eath. Do not ent	er the mode of dying	g, such as cardia	or respiratory arres	st,	Approximate Interval Between
FFEMALE: 23d. Date of delivery 23d. Date of deli	,007	8.8		if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a cons	equence of).					
State	ROX .		cian/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time o	etaf death 3 🗆					
State	ς, T	equires that en signed by	ed by Ph				nderlying cause give	en in Part I.			
The state of the s	Ä	The la		0 0	ral d	128 po	912		autopsy perform	ed? prior to death?	completion of cause of
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature		siciar cartif recto	00	examiner?	spital:		- Cthe				
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature	ō	Phy or this			28a. Date of fnjury	28b. Time of	28c. Injury	4 ☐ Nursing F			cify)
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature	<u></u>	th. T. Afte	tion		(Month, Day Year)	Injury				,	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MRJE (CODYNM) KUNM! State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	DIVIS	itel or Atterns after des el Director led in by the	Certifica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At building, etc. (Spe	thome, farm, streetfy)	eet, factory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	ural Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAJE (CODUMN) KUNN) State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		the Hosp hin 24 hou the Funal npletely fil		one)	er: On the basis of exami	nowledge, death ination and/or inv	estigation, in my op	oinion, death occu	irred at the time, dat	te and place, and due	o to the cause(s)
		To To		10120		ac : =	26	3721	0 1	0.23.2	down
DOT 9 E 2006 Real A Angel 1	B	Sta	ite	MAJE(いかい。 31. Date filed (Month, Day, Year)	32. Registrar's Sig	IMMI	Print) NOS	A S.	MASH	MOTION 1025 C	- EASTS

06-07855 John Bell

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) Physician/ 0908 hrs Medical Examiner John October 19, 2006 Bell 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 7844 Bethany Lane La Plata Charles If Under 1 Year | If Under 24Hrs 8. Date of Birth(MM/DD/YYYY) 9 Birthplace (State or 6. Sex 5. Social Security Number Age (In yrs. last birthday) **Funeral** Months Days Hours Count Washington Director Sept.30,1952 218-56-6716 2 1 XM Usual Residence of Decedent IOc City, Town or Location 10d Inside City Limits 10b. County 1 X Yes 2 No or 28a-f show LaPlata Maryland Charles notified at once, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10f. Zip Code 10g Citizen of What Country? 10e. Street and Number 7844 Bethany Lane 20646 U.S.A or items 23a Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black þ If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. Never Married Married Yes Specify: White f Yes, Give Year Widowed 4 X Divorced Yes 2 No specify "natural", the Medical Examiner ģ 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life DO NOT use retired) Elementary/Secondary (0-12) ment of Health and Mental Hygiene tant: If item 27 is marked other than or other traumatic event, the Medical Baltimore, MD 21215-0036 2 U.S. Government Fireman 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William A. Bell Agnes Η. Owen 19a. Informant's Name/Relationship (Type, Print) 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ပ Matthew K. Bell 115 Versailles Circle, Apt. E, Towson, Md. 21204 Son 20a Method of Disposition 20b Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Place of Disposition (recommendate) oct. Burial 2 X Cremation 3 Removal from State Alexandria, Virginia Metropolitan Funeral Service Donation 5 Other Specify uneral Service Ligensee

22. Name and Address of Facility
Williams Funeral Home, P.A.
4270 Hawthorne Rd., Indian Head, Indian Head of dying, such as cardiac or respiratory arrest, shock, or heart 21. Signature of Funeral Service 20640 Mc Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death a. Acute coronary thrombus Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) b. Atherosclerotic Cardiovascular Disease Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transi Hospital or Attending Physician: The law requires that the death certificate be executed Sa g physician a the burial -UNPENDED AMENDED Physician/Medi O. Box 68760. 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Day Live birth Fetal death 3 Ectopic pregnancy Month Year as Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown this certificate has been signed by the director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, P. 1 Yes 2 No 3 ✔ Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other₄ Hospital: 1 Inpatient 2 Nursing Home 5 Residence 6 Other. Scene ER/Outpatient 3 this 1 🗸 Yes 2 After 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d Describe how injury occurred Manner of Death 28b Time of Injury Certification: those after acase.

A 24 hours after acase.

The Funeral Director: A'

The first of the first of 1 V Natural 1 Yes 2 No Pending Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical (Check only To the To the 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) Hanua Buthall, m OCME October 20, 2006 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day Year) 0 C 1 2 4 2006 strar's Signatur State Registrar

State of Maryland / Department of Health and Mental Hygiene [] [] [Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) **Physician** Year)Ctora /Medical Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner OL Year If Under 24 Hrs. If Under 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 01/14/1939 Birthplace (State or Foreign Country) Social Security Numbe **Funeral** Days 1 □ M 2 🗓 F 67 172-30-7479 PA Director Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location in than "natural", or Itema 23a or 28a-f show the Medical Examinar must be notified at MD OUEEN ANNE'S CHESTERTOWN 1 Tyes 2X No Directo 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 103 DUTCHESS ROAD 21620 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married WHITE Maryland 21215-0036 1 Tes 2 No þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) TEACHER EDUCATION rmit. Pages 1 and 2 should be filed w spertment of Health and Mental Hygien portant: if item 27 is marked other to ly njury or other traumetic event, #1 other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOSEPH GILBERT SCHOLL MARGARET CAMPBELL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) RICHARD BISH/HUSBAND 103 DUTCHESS ROAD, CHESTERTOWN, MD 21620 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Slate 1 Burial 2 ☐ Cremation 3 ☐ Removal from State CRUMPTON CEMETERY 10/23/2006 CRUMPTON, MD 4 □ Donation 5 □ Other (Specify) permit.
Deportre
Importe
any nju 21. Signature of Funeral Service License FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME 130 SPEER ROAD, CHESTERTOWN, MD 21620 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** LIV /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was debedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a o. 9 Unknown ے signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did lobacco use contribute to the cause of death? Records, þ 3 Probably 1 ☐ Yes 2 ☐ No 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 No of Vital : After this certifical funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 Tyes 2√ No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Anner of Death 1 Natural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred or Attending Division 5 Pending 1 ☐ Yes 2 ☐ No death investigation 2 Accident Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 | Homicide To the Hospital o within 24 hours aft To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10 ...o completed cause of death (Item 23a) (Type, Print) 30. Name and address of perso. Blog B Chestertown MD 21620 130 However tero

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

						Cer	tificate of	Death		Reg. No	06	354	73
	Physici	n l	1. Decedent's Name (First, Middle, La.	st)					2. Date of D Month	Day	Year	3. Time of [Death
	/Medic		MYRTLE LEE	BECHTE	L					ER 20,		8:40	AM
1	Examin	er	4a Facility Name (If not institution, giv						, or Location of Dea			_	
			11201 SHARPTO						A SPRING		OMIC	_	
9	Funeral Director		5. Social Security Number 6. S 221-20-3221 Usual Residence of Decedent	ex 7. Ag □M 2 💢 F	72	st birthdey) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Bi (Month, D 1-8-19	irth a <i>y, Yeer)</i> 934	9. Birthp Coun	lace (State or try) DE	Foreign
	pue & m		10a. State 10b. County		10c. City,	Town or Loc	ation				1	0d. Inside City	Limits
	Ba-f sh	ctor	1ARYLAND WICOM 10e. Street and Number 1.1.2.0.1 SHARPTOW	ICO	MA	RDELA	SPRING	GS				1 ☐ Yes	2 X No
	ath with the 23st or 2	rai Dir	10e. Street and Number 11201 SHARPTOW				10f. Zip Code 2183	<u></u>		10g. Citizen of	CA		
020	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mentel Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 █ If Yes, Give Year or Dates:			Vas Decedent of H Yes, specify Cuba ☐ Yes 2 XNo	lispanic Origin an, Mexican, F Specify:	? (Specify Yes or N Puerto Rican, etc.)	Bia	ce - Americ ck, White, y: WHI	etc.	
5	72 h	etec	15. Decedent's Ed (Specify only highest gre	lucation de completed)		(Give I	ent's Usual Occup	during most of	working	16b. Kind of B	usiness/Ind	dustry	
21215-0020	yiene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. D	O NOT use retired ISTRESS	a)		SEWIN	G		
Maryland	2 should be filed within and Mentel Hygiene. Is marked other than aumatic event, the Manault event, the Manault event, the Manault event.	Be	17. Father's Name (First, Middle, Last) ALLEN DALE						Name (First, Middle EN ELIZA			т.т.	
<u> </u>	should nd Men marke umatic	P	19a. Informant's Name/Relationship			19b Mailin	Address (Street		or Rurel Route Numi				
S	end 2 sho salth end or traum		THOMAS S. BECH		ON				RD.MARD				2183
re,	of Hea		20a. Method of Disposition		20b. Pla	ce of Dispos	ition (Name of		Date	20c. Location			2100
Ē	Peges nent of ant: if the ury or o		1 M Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ 9ther (Specify		100	D FEL CEMET	LOWS Place		10/25/0	6 SEAF	ORD,	DELAW	ARE
Baltimore,	permit. Pag Department Important: i any injury o		21. Signature of Funeral Service Licer	600 / 1 /2	to	- ²²	ATSON-	ŶATES	FUNERAL	HOME,	INC.		
			10/4/	V. Ju	wy				WARE 19		-		
-		1	23a. Part. Enter the disease, or com- shock, or heart failure. List only	olications that aused one cause of each li	ne.	Do not ente	r the mode of dyin	ig, such as ca	rdiac or respiratory a	arrest,	4	Approximate Interval Betw Onset and D	een
	Physician /Medicai		Immediate Cause (Final	M	1 7	1.	1.1		encer		1		
	Examiner		disease or condition resulting in death)	a. ///25	Tosta	til	C6/07	? (ence				
		je			Due to (or a	as a consequ	Jence ot):				1		
	icate be exacuted physicien end s the burial-trensit	edicai Examiner	Sequentially list conditions,	b. —	Due to (or a	as a consequ	uence of):						
Ö,	e exe	Ĕ	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								į		
68760,	sate b ohysic the b	dica	that initiated events resulting in death) Last	0.	Due to (or a	s a consequ	ence of):				1		į.
9 X	eath certific ettending pl	Σ∣		d							į		
Вох	eath ce ettendi	clar							ont Bid			4	(do - A) O
P.O.	lew requires that the death certificate be executed es been signed by the ettending physicien end as Should be deteched for use es the bunel-trensit	Physician/	Part II. Other significant conditions of	ontributing to death bi	ut not result	ing in the un	derlying cause giv	en in Paπ I.		Yes 2010 No		oably 4⊟ U	
ds,	uires that signed Id be del	d b							24a Was	s an autopsy		ere autopsy fir	
Vital Records,	w require s been si 2 should	Completed							perf	ormed?	co	ailable prior to mpletion of ca death?	
æ	The lew ate hes pege 2	E							10	Yes 254No	10	Yes 25	; No
ital		Be	25. Was case referred to medical					26. Place of	Death (Check only	one)			
Z	Physician: this certific	10	examiner? 1 🗆 Yes 🥦 No	Hospital:	ont 2 E	R/Outpatient	3□ DOA Oth	er: 4 🗆 Nursi	ng Home	idence 6 Oth	er (Specif	()	
n of	ng Phy ter thi neral		27. Manner of ath Natural 5 ☐ Pending	28a. Date of Inju (Month, Day	ry y Year) 2	8b. Time of Injury	28c. Injur Wor	y at k?	28d. Describe	how injury occur	red		
Sio	Attending or deeth.	catic	2 ☐ Accident investigation					Yes 2□No					
Division	To the Hospital or Attending Phywithin 24 hours effer deeth. To the Funeral Director: Affer thi completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injude	ury - At hom c. <i>(Specify)</i>	e, farm, stre	et, factory, office			(Street and Numl own, Stete)	ber or Rura	l Route Numb	⊅er,
ш	ppital ours peral filled	2	29a. Certifier SertifyIng Ph	yeician: To the best of	of my knowl	edge, death	occurred at the tin	ne, date and p	lace, and due to the	cause(s) and ma	anner as si	ated.	
	To the Hospital within 24 hours To the Funeral completely filled	edicai	(Check only one) Medical Exam	Iner: On the basis of and manner sta	examinatio	n and/or inv	estigation, in my o	pinion, death	occurred at the time	, date and place,	and due to	the cause(s)	
	Total Vith	₹)[29b Signature and title of certifier	M	/	Λ	29c. Licens	e number	70	29d. Date signe	d (Month,	Day, Year)	
	128		PDI CH		m	<u> </u>	No	162	10	10 -	27-	06	
	10		30. Name and address of person who of Dourd E. Cours!	completed cause of d	eath (Item 2	3a) (Type, F	Print)	30×173	3 Sali	sh, 1	uD	2180	2
	Sta Registr	- 4	31. Date filed (Month, Day, Year) OCT 2 4 2		ar's Signatu	re A	0.00			0			

amend 1, per Dr. g861 11/9/06 KBH
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		t of Health and Mental Hygier 006 35474
Physician /Medica	Decedent's Name (First, Middle, Last) Damion Damian Scott BENED	2. Date of Death Month Day Year 105 Prh
Examine	Facility Name (If not institution, give street and number) 4b. City. Breater Beithmore Medical Center B	Town, or Location of Death Althore, MD Ballimore
Funeral Director	is Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) Yrs. If Under Months	
36 Ster death with the Maryland of them a 23e or 28e-1 show and the modified at the modified a	Joan Residence of Decedent	10d. Inside City Limii 1 ☐ Yes 2 ☒ N
ff My j O M site death with the Mai referent 23a or 28a-f single multiple multiple for multiple		.102 USA
336 urs after der sall, or Itema	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	tent of Hispanic Origin? (Specify Yes or No- city Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White
7 24	Elementary/Secondary (0·12) College (1-4or 5+) life. DO NOT us	rk done during most of working se retired)
and 2 the filed value of other to event, the	Infant Tr. Father's Name (First, Middle, Last)	Infant 18. Mother's Name (First, Middle, Maiden Sumame) Crosset al. I. Litter
Maryland de should be fill and Mental the stranged out traumatic even		(Street and Number or Rural Route Number, City or Town, State, Zip Code) Run Rd. Manchester, Md. 21102
Baltimore, Maryland 21215-0 permit. Pages 1 and 2 should be filled within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature eny injury or other traumatic event, tra Modical process."	20a. Method of Disposition 20b. Place of Disposition (Nam cemetery, crematory or of	ne of Date 20c. Location - City or Town, State
Balti permit. Departm Importa eny inju	21. Signature of Funeral Service Licensee 22. Name and	d Address Hearth Chapel P.A. harmil Dr. Manchester, Md. 21102
Physician /Medical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) A. Sevel resulting in death) Due to (or as a consequence of):	ind metabolic acidos Sonset and peath
60, be executed cian and purial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Underlying Due to (or as a consequence of): C. Due to (or as a consequence of):	ren Syndrome 8-9the trenty
Division of Vital Records, P.O. Box 687 or Attending Physician: The law requires that the death certificate after death. Director: After this certificate has been signed by the attending physic in by the funeral director, page 2 should be detached for use as the integral of the Completed by Divisional Completed for the physician To Be Completed by Divisional Completed for the physician of the completed for the physician of the completed for the physician of the completed for the physician of the completed for the physician of the completed for the completed for the completed for the complete f	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	
rds, P quires that m signed b	Part II. Other significant conditions contributing to death but not resulting in the underlying ca	ause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknow
I Record The law requir cate has been si	·	24a. Was an autopsy findings availab prior to completion of cause of death? 1 □ Yes 2 ☑ No
of Vital Rephysician: The Ithis certificate had this certificate had director, page	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Impatient 2 ER/Outpatient 3 DO	26. Place of Death (Check only one)
Division or transfer of a state o	2 Accident investigation M	8c. Injury at 28d. Describe how injury occurred Work? 1 Yes 2 No
DIVISIO	4 Homicide determined 286. Place of injury - At nome, farm, street, factory building, etc. (Specify)	
Divisic To the Hospital or Attention within 24 hours after death To the Funeral Director: completely filled in by the Indianal Consideration	(Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, and manner stated.	at the time, date and place, and due to the cause(s) and manner as stated. In my opinion, death occurred at the time, date and place, and due to the cause(s) License number 29d. Date signed (Month, Day, Year)
To To Court	Maria a Pane mo D	004615P 9/21/06
State	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Charles Shoct Baltim (31. Date filed (Month, Pay, Year) 32. Registrar's Signature	ore, MD 21204
Registral	NOV 0 9 2008	

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar		State of I	Marylan		artmen rtificate			d Mental Hy	giene 0	06	35475
A Control	Physici		Decedent's Name (Jean	First, Middle, Last)		В	order				2. Date of D Month Oct 28,	eath 2006	Yeer	3. Time of Death 10:08am
	/Medio Examir		4a. Facility Name (If no	-		er)		1	Town, or	Location of De			y of Death	
	Funeral Director	<i>2</i>	5. Social Security Num 219-52-04	ber 6. Sex			last birthday) Yrs.	If Under Months		II Under 24 h	Ars. 8. Date of B			place (State or Foreign ntry)
	show	'n	Usual Residence of D- 10a. State 1 MD	ecedent Ob. County Allegany	/	10c. Cit	y, Town or Lo							10d. Inside City Limits 1 Xes 2 No
	or 28a-1	Funeral Director	10e. Street and Numb	9r				10f. Zip			, , , , , , , , , , , , , , , , , , , ,	10g. Citizen of		
	eath w	erail		ntana Ave	enue 2. Was Decede	nt Ever in II	S 13	Was Decor		21502	(Specify Ves or N		SA	can Indian,
036	urs after del', or Item	þ	11. Marital Status 1 ☐ Never Married 3 ☐ Widowed 4	2 Married	Armed Force 1 Tes 2 If Yes, Give Year or Date	s? X No		If Yes, spec		Specify:	(Specify Yes or N erto Rican, etc.)	i	ick, White,	etc.
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show important: If item 27 is marked other than "naturel", or items 23a or 28a-f show applying or other traumatic event, ite Mydical Exam and must be traited at ance.	Completed		5. Decedent's Educionly highest grade ary (0-12)		or 5+)	16a. Dece (Give life. Home		rk done d se retired)	ition luring most of	working	16b. Kind of E		ndustry
and 21	d be filed wantal Hygier to event, the	To Be Col	17. Father's Name (Fi	rst, Middle, Last)			попне	паке			Name (First, Middle Ida (Iser)	e, Maiden Suma		
Mary	nd 2 should Ith and Men 27 Is marke r traumatic	Ĭ	19a. Informant's Nam Naomi Fa	e/Relationship (Typ	_{рө, Print)} dau	ghter	19b. Mailir 111	ng Address 14 Mo	(Street a				, State, Zi	у Соде) ИD 21502
more,	Pages 1 and 3 nent of Health int: If item 27 iry or other tr			sition Cremation 3 Re Other (Specify)	emoval from Sta		Place of Dispo cemetery, crei stlawn M	natory or o	ther place	dens	Date 11/1/2006	20c. Location		own, State
Balti	permit. F Departm Importar eny injur		21. Signature of Fune		1/1	111	1) 22				Home, P.A nue; Cumbe		21502	
	Physician /Medical		23a. Part. Elter the shock, or heart I Immediate Eause (Fil disease or condition resulting in death)		Cer	ebro	Vasa	er the mod						Approximate Interval Between Onset and Death
4	Examiner	ler	Sequentially list cond.	itions, b		as a conseq								
8760, V	ficate be executed physicien and is the burial-transit	cai Examiner	cause. Enter Underly Cause (Disease or inj that initiated events resulting in death) Las	c c	Due to (or	as a conseq	uence of):							
.O. Box 68	death certi e attending nd for use a	Physician/Medical	IF FEMALE: 23b. Was decedent p in the past 12 m 1 Yes 2 1	onths?	3c. If yes, outcor 1 Live birth 4 Pregnan 9 Unknow	2 ☐ Feta t at time of d	Ideath 3	Ectopic pr Other (sp				1	ate of deliv	ery Day Year
<u>α</u>	8 5 6	by	Part II. Other significa	ant conditions con	tributing to deat	h but not res	ulting in the u	nderlying c	ause give	on in Part I.		tobacco use cor		he cause of death?
of Vital Records,		Completed								-		s an 24b. opsy ormed? 22 No	prior to co death?	opsy findings available impletion of cause of
Vita	ilcian: Th certificate rector, pag	Be	25. Was case referred examiner?	н	ospital:				Othe	· -	Death Check only			
on of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	ıtlon: To	1 Yes 2 No. 27. Manner ol Death 1 Natural 2 Accident	5 Pending	1 ∐ Inp.		ER/Outpatier 28b. Time o Injury		8c. Injury Work	4 Jursin	g Home 5 Res	how injury occu		fy)
Division	in the	Certification:	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of building,	Injury - At he etc. (Specif	ome, larm, str (y)	eet, factory	r, office			(Street and Num own, State)	ber or Run	al Route Number,
	To the Hospital within 24 hours a To the Funeral completely filled	edical C	29a. Certifier (Check only 2) one)	Certifying Phys	ician: To the besider: On the basis	s of examina	owledge, deat ation and/or in	h occurred vestigation	at the tim	e, date and plainion, death o	ace, and due to the	e cause(s) and m	anner as s , and due t	stated. o the cause(s)
	To the complete of the complet	Σ	29b. Signature and tit	le of certifier	hob			290	: License	number 003328	80	29d. Date sign	ed (Month,	
	X		30. Name and addres	s ol person who co	mpleted cause of	ol death (Iter								
16	Sta	ate	31. Date filed (Month,			istrar's Signa	ature			ue Cum	berland N	1D 21502	2	
	Regist	- m	N	OV 0 9 201	06	Pear 1	B A	need	0					

			1 - For State Registrar	State of Ma	aryland .	/ Depa		of He	ealth ar		ental Hyg	giene	71116	354	76
	Physici /Medio		1. Decedent's Name (First, Middle, Lydia	Anne Bu	tterwo	orth				1	2. Date of Dea Month October	- 29°	, 2006		
	Examir	ner	4a. Facility Name (If not institution, g 375 Pearl Stre	et	e (In yrs. last	hirthday		ede:	ocation of rick If Under 24		Date of Right		Frederi	ick	- Foreign
	Funeral Director		217-58-3946 Usual Residence of Decedent	1 M 2 M F	46	Yrs.		Days	Hours	Min.	B. Date of Birtl (Month_Day Oct 5,	196	0 Was	thplace (State or ountry)	, DC
	death with the Maryland me 23a or 28a-1 ehow Frount be notified at	ctor	Maryland Freder	ick	10c. City, T		erick							10d. Inside Cit	
:	23a or 2	Funeral Director	375 Pearl Stree				10f. Zip C		21701			U	sen of What C		
		þ	11. Marital Status 1. Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1		1	Was Decede If Yes, specif 1 ☐ Yes 2[in? (Spec Puerto R	ify Yes or No- ican, etc.)		14. Race - Am Black, Whi Specify:		
7-0-7	within /< nours arter ene. then "natural", or ite	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	grade completed) College (1-4or 5		(Give	dent's Usual kind of work DO NOT use Protec	done du retired)	iring most o	of working			nd of Business	Instit	utior
and 2	id be riled entat Hygie ked other ic event, II	To Be Co	17. Father's Name (First, Middle, La Clair Willi		erwort					's Name (First, Middle,	Maiden	Sumame)	brand	
Mary	ind 2 should be with and M in 27 is mar		19a. Informant's Name/Relationship Mrs. Elizabeth E										r Town, State, Maryla		
Saltimore	reges 1 a ment of He ant: If item ury or oth		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 4 □ Donation 5 □ Other (Spec		ceme	etery, crer.	sition (Name natory or oth g Crei	er place	ry Oc	Da et 30			cation - City or .thsbur	Town, State g, Maryl	Land
Dall	permit. Pege Department of important: if any injury or once.		21. Signature of Funeral Service Oc	een	M00706	10	b Eas	t Ch	urch	St,	Freder	ıck,	l Home Maryl	and 2170)1
S inov	been signed by the attending physicien and should be detached for use as the burial-transit	dical Examiner	23a. Part 1. Enter the disease, or co shock, or heart failure. List on immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	mplications that caused by one cause on each lin a. Motasta Due to (or as a b. Due to (or as a c. Due to (or as a d.	a consequent	ce of):				ardiac or	respiratory and	est,		Approximate Interval Betw Onset and D	veen leath
0	ine death certifications by the attending phacehold for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 1	2 🗌 Fetal de	ath 3	Ectopic pred Other (spec					2	23d. Date of de Month		ear
ras, r	nie law requires mat uie ate has been signed by th page 2 should be detache	ρ	Part II. Other significant conditions	contributing to death bu	ut not resultin	ng in the ur	nderlying cau	use giver	in Part I.			baccou es 2		o the cause of de	
II Recor	ate has	Completed									24a. Was a autops perfor 1 Yes	SV	prior to death?	utopsy findings a completion of ca	vailable use of
A II d	certifi	Be	25. Was case referred to medical examiner?	Hospital:				Other		-	Check only or				-
	ding rijerden. The lay th. After this certificate has funeral director, page 2	tlon; To	1 Yes 22 No 27. Manner of Death Natural 5 Pending 2 Accident investigat	28a. Date of Injur (Month, Day	v 28	Outpatien b. Time of Injury		c. Injury : Work?	at	28	d. Describe h		Other (Spe	icity)	
DIVIS	to the nospital or Attending ripsicial, within 24 hours elicadeth. To the Funeral Director: After this certifica completely filled in by the funeral director,	Certification;	3 Suicide 6 Could not determine	be One Diese of Iniv	ury - At home c. (Specify)	, farm, str	eet, factory,				f. Location (S City or Tow			ural Route Numb	9 9 r,
	in 24 hour	edical	one)	Physician: To the best of ammer: On the basis of and manner sta	examination	dge, death and/or inv	occurred at vestigation, in	the time	, date and ; nion, death	place, an	d due to the c	ause(s) late and	and manner a place, and due	s stated. e to the cause(s)	
	with To	Σ	29b. Signature and title of certifler	JA M	ID			License) 4		4			signed (Mon		
	D		30. Name and address of person who Elhamy ESK	ander, x	10	501	Print)	7th	Stre	et:	Frede	rick	C M	06)(
	Sta Registr		31. Date filed (Mohth, Day, Year)	10 h	ar's Signature		Par Blo	-							

35477 State of Maryland / Department of Health and Mental Hygien ? 11 6

Physician	
/Medical	
Examiner	4

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Iteme 23a or 23e-f show any injury or other traumatic event, the Medical Evantinal must be notified at one.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, W

•	1 - State Registrar	•	Cer	tificate of I	Death		Rag.	No.	, 00111
1	1. Decedent's Name (First, Middle, Las	Theodore	Blen	tlinger			Date of Death Ctober	31, 20 0 8	3. Time of Death 11:53 P _{4M}
r	4a. Facility Name (If not institution, give Northampton Manor	Nursing Cente			ederi	ck			ederick
	5. Social Security Number 6. Security Number 218-36-3379 Usual Residence of Decedent	ex 7. Age (In yrs. XM 2□ F 94	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. Fe	Date of Birth (Month, Day, Ye D. 4, I	912 9. E	irthplace (State or Foreign Country) Mary Land
CIO	10a. State 10b. County Maryland Frede		y, Town or Loc		ew Mar	ket			10d. Inside City Limits 1 ☐ Yes 2 No
מומ	10e. Street and Number 6300 Boyers Mill			10f. Zip Code		1771		U.S.A	
noy ruile	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	If	Vas Decedent of H Yes, specify Cuba ☐ Yes 2 X No	spanic Origin, Mexican, I	n? (Specify Puerto Rica	y Yes or No- an, etc.)	14. Race - Ar Black, Wi Specify:	nerican Indian, hite, etc. White
Julpiere	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		(Give A	ent's Usual Occup kind of work done OO NOT use retired 'Y Farmer	fu <i>rina</i> most c	of working	16b	. Kind of Busines Dairy I	
2000	17. Father's Name (First, Middle, Last) Ira B	Blentlinger	Dair	y razmer	18. Mother's	s Name (Fi	irst, Middle, Maid Pearl		
	19a Informant's Name/Relationship (7 William T. Blentli			g Address <i>(Street</i> East Pat					
4	20a. Method of Disposition 1 ♥ Burial 2 □ Cremation 3 □ □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Light 23a. Part1. Enter the disease, or comp	Removal from State Res	sthaven	Name and Addresency and	l Gard	rd Fu	Nov. <u>5,</u> neral Ho	ome	rederick, MD.
	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Pue to (or as a conseq CO PD	To	THRIU		ardiac or re	spfratory arrest,		* Approximate Interval Between Onset and Death
dical Evalling	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conseq c. Due to (or as a conseq d.							
iyəlcidi izind	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	l death 3 🗍	Ectopic pregnancy Other (specify)				23d. Date of o	delivery Day Year
וכת הא נ	Part II. Other significant conditions of DE mew TIM		ulting in the un	derlying cause giv	en in Part I.	_	23e. Did tobacc	. /	to the cause of death? Probably 4 DUnknown
Did III							24a. Was an autopsy performed 1 ☐ Yes 2 ☑	death	autopsy findings available o completion of cause of ? es 2 \(\) No
מ מ	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ER/Outpatient	Oth			heck only one)		
	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Wor		28d.	5 Residence Describe how in		овспу)
	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, stre	eet, factory, office		28f.	Location (Street City or Town, St		Rural Route Number,
מחורשו	29a. Certifier (Check only one) 1 ← Cartifying Phyone 2 ← Madical Example 1	ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death tion and/or inv	occurred at the tin estigation, in my o	e, date and pinion, death	place, and occurred a	due to the cause at the time, date	e(s) and manner and place, and d	as stated. ue to the cause(s)
A	29b. Signature and title of certifier	- HD		29c. Licenso	+7951			Date signed (Mo	
	30. Name and address of person who of Sibte A. Kazmi	, M.D., 814 To	ll Hou	•	e, Fre	deric	k, Mary]	land 217	01
•	31. Date filed (Month, Day, Year)	32. Registrar's Signa	M. A.	met					

State

Registrar

			State of Maryland / Department of Health and M 1- State Amend Items 23a Pt I,II,25,27,28a; free ME,C861,1	ental Hygien L 1/16/06dh Reg. N	2006 35478
	Physici	an	1. Decedent's Name (First, Middle, Last)	11.	ay Year 1617
	/Medic Examir		Aretta Burbage 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	10 26	c. County of Death
			Pentinsura Regionor Mediosi Centre SAUSBURY		Nicomics
	Funeral Director		5. Social Security Number 221-16-6119 6. Sex 1 Months Days Hours Min.	8. Date of Birth (Month, Day, Year 11-28-192)	
	show		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	e Mar	ctor	MD Wicomico Pittsville		1 ☐ Yes 2X☐ No
	with th	Dire	10e. Street and Number 10f. Zip Code 4994 Powellville Road 21850		itizen of What Country?
	death with the Maryland ms 23a or 28a-f show rmust be notified at	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe	city Yes or No-	SA 14. Race - American Indian,
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any njury or other treumatic event, the Medical Examinar must be notified at once.	þ	Armed Forces? If Yes, specify Cuban, Mexican, Puerto F 1 □ Never Married 2 □ Married If Yes 2 □ No If Yes Give Year or Dates: If Yes, specify Cuban, Mexican, Puerto F 1 □ Yes 2 □ No Specify:	Rican, etc.)	Black, White, etc. Specify: White
215-0036	within 72 ho ene. than "natur ha Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. I	Kind of Business/Industry
2	filed wi Hygien ther th		7 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name	Ov (First, Middle, Maide)	vn Home
Maryland	ental H ked of	To Be	YT: 11		n Sumame)
ary	should and Men smarke sumatic	F	WIIIIam Wooters Lillian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural		or Town, State, Zip Code)
	and 2 lealth a m 27 i		Douglas Burbage - son 4770 Burbage Crossing,		
Baltimore,	Pages 1 nent of H ant: if ite ary or oti		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)		ocation - City or Town, State
Balt	Depentit.		21. Signature of Euneral Service Lice see 22. Name and Address of Facility Bour 705 E. Main Street,	nds Funera	1 Home
			23a. Part1. Enter the disease, or commications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List gray one cause on each line.	r respiratory arrest,	Approximate Interval Between
d	Physician		Immediate Cause (Final disease or condition Introcycnic Hemorrage		Onset and Death
1	/Medical Examiner		Due to (or as a consequence of): Hypertension	. /	164
		Je	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying	1/1	JER XCICLE
	ecuted Ind transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C.	THE ALEXAM	
68760,	cate be executed physicien and the burial-transit	ai E	if any, leading to immediate cause. Enter funderlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to or as a consequence of): Due to or as a consequence of):	WED BY WILL	
687	ifficate g phys as the	edicai	d.		
P.O. Box	The law requires that the death certificate best been signed by the attending rage 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		23d. Date of delivery Month Day Year
Records, P	uires that signed b	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. End Stage Renel Disease.		use contribute to the cause of death?
CO	aw requ s been 2 shoul	piete	Congestive Heart Failure	24a. Was an	24b. Were autopsy findings available
R	The lav	Completed	Dichetis Mellitus, Subdural Hematoma	autopsy performed? 1 ☐ Yes 2 ☐ No	prior to completion of cause of death? 1 □ Yes 2 □ No
of Vital	Physicien: Th this certificate rat director, pag	Be	25. Was case referred to medical examiner?	Street Street	
	Phys this rai dia	2	1 Inpatient 2 EH/Outpatient 3 DOA 4 Nursing Hom	ne 5 Residence	
ion	ath. r: After ne funer	atior	27. Manper of Death 1 Natural 5 Pending 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 3 Work? 28c. Injury at Work? 1 Yes 2 XNo	Probable	
Division	al or Attending s after death. I Director: After d in by the fune	Certification:	3 Suicide 61 Could not be	8f. Location (Street ai City or Town, State	nd Number or Rural Route Number, e) OWN
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fun	edicai (29a. Certifier (Chart only one) 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner stated.	nd due to the cause(s d at the time, date an	and manner as stated. d place, and due to the cause(s)
	To th within To th comp	Me	29b. Signature and title of cedifier 29c. License number	29d. Da	ite signed (Month, Day, Year)
•	VOR.		mb D54127		10/21/06
(7 gr		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alon DAVIS mp 100 Power St. Salisbury	mo 218	604
	Sta Registr		31. Date filed (Month, Day, Year) OCT 2 4 2006 32. Degistrar's Signature		

DHMH 17 Rev 1/2001

Fox to ME #23a

State of Maryland / Department of Health and Mental Hygien 2 0 6 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** WALLACE 23, MCCLAIN COOK oct. 2006 11:04AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Columbia Howard Lorien Nursing Home If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1MM 2□F 88 Yrs. Director 549-34**-**1934 June 10,1918 MD Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or Items 23s or 28s-f ehow the Medical Examiner must be notified at MD Howard 1 **2** Yes 2 □ No Director Columbia 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 5241 Eliots Oak Road 21044 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specity: þ Specify: 3 ☐Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City Bus Driver 10th 7 ie marked othe traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ie marked o Pages 1 and 2 should be Clara Parker Charles Cook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health an
Important: If Item 27 ie
any injury or other trau Denise Turner-Daughter 3574 Willow Tree Trace Decatur, GA 30034 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Fnrl Svcs 10/25/06 Alexandria, VA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Snowden Funeral Home, PA 246 N. Washington St Rockville, MD 20850 26a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Ureterral Cancer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical use as tha attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death ned by the ai 5 Other (specify) Ö 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 Yes 2 No 3 Probably 4 Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA After this co 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 2 Accident s after dec. 5 Pending Injury М 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital
within 24 hours a
To the Funeral I Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10/25/06 D0053709 CHW 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14300 Gallant Fox Lane, #210, Bowie, MD 20715 Raj Chawla, M.D. 31. Date filed (Month, Day, Year) 32/Registrar's Signature State OCT 2 6 2006 Registrar

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

OCT 3

32. Registrar's Signature

			1 - For State Registrar	State of M	laryland /		artmen rtificate			and M		giene Reg. No. 0	06	35482
	Physici	an	1. Decedent's Name (First, Middle, Li	ast)							2. Date of De	eath Day	Year	3. Time of Death
	/Medi		Betty Jane Cla								10	24	2006	6:20 a M
	Examir		4a. Facility Name (If not institution, gi)				Location of	of Death			nty of Death	
	Funeral		Atlantic General 5. Social Security Number 6.		ge (In yrs. last b	irthday)	Ber If Under		If Under	24 Hrs.	8. Date of Bir	th	ceste	
	Director			1□M 24☐F	79	Yrs.	Months	Days	Hours	Min.	(Month, Da	4 1927	MD	place (State or Foreign ntry)
	pu ,		Usual Residence of Decedent		10 00 7									
	aryfa shov	5	10a. State 10b. County		10c. City, To		cation							10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	28a-f	Director	MD Worcest 10e. Street and Number	er	Berlir	1	104 7:-	0-4-				10- 0%	(11/1 -1 0	
	with Sa or	Dir					10f. Zip					10g. Citizen o	or what Cou	ntry ?
	ns 23	Funeral	818 Ocean Parkwa	12. Was Decedent	Ever in U.S.	13. \	218 Was Deced		spanic Orie	gin? (Spe	cify Yes or No	USA 14. B	ace - Ameri	can Indian.
9	72 hours after death with the Maryland natural', or Items 23a or 28a-f show disal Examerer must be redified at		1 ☐ Never Married 2 🔀 Married	Armed Forces						, Puerto I	cify Yes or No Rican, etc.)		lack, White,	etc.
933	ural',	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1 □ Yes ;	ON KIN	ъреспу:			Spec	oify: W	hite
5-	"natu	Completed	15. Decedent's E (Specify only highest g		16	a. Deced (Give	dent's Usua kind of wor DO NOT us	il Occupa rk done d	ition <i>uring</i> most	t of worki	ng	16b. Kind of	Business/In	dustry
12	within ene. than	dmo	Elementary/Secondary (0-12)	College (1-4or								Tolon	home	Commission
9	filed Hygie other		17. Father's Name (First, Middle, Las	t)	[[6	ICTT.	ities	ASS.				Maiden Sum		Service
an	lid be lental kad c	To Be	John J. Greenwa	1t					Li11	v Ma	e Poble	etts	ŕ	
Maryland 21215-0036	d 2 should be filed within 72 hours after death with the Marylan It and Mental Hygjene. It and Mental Hygjene. 77 is marked other then "natural", or Items 23a or 28a-f show traumatic event, the Medical Examinating to red	_	19a. Informant's Name/Relationship	(Туре, Print) Spou	ise 19	b. Mailir	g Address	(Street a		-		er, City or Tow	m, State, Zip	Code)
			Charles Stevenso	n Clark Jr					rkway	, Be	rlin, l	MD 2181	1	
Baltimore,	of to		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 (☐Removal from State	20b. Place cemet	of Dispo ery, cren	sition (Nan natory or o	ne of ther place	9)	D	ate	20c. Location	n - City or To	own, State
Ë	tant:		*4 □Donation 5 □ Other (Spec	ify)	Cape	Hen]	Lopen	Cre	n. 1	0/25	/2006	Frankf	ord,	DE
Bai	permit. Pag Department Important: I any injury o		21. Signardie of Fun Service Lice	Zurfala.		10	O MT.	LITAI	n St.	, ве	riin, r	ge Fune 4D 2181	ral H	ome
			23a. Part1. Enter the disease or cor shock, or heart failure. List only	nplications that cause one cause on each I	d the death. Do	not ente	er the mode	e of dying	, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Between
	Priysician		Immediate Cause (Final disease or condition resulting in death)	a. Seps	sis								- 4	Onset and Death
	/Medical Examiner		resulting in death)	Due to (br as	a consequence	e of):								
		P.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence	7 (5 e of):								
	uted d ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter the deskip Cause (Disease or injury that initiated events		9									
o,	an an an an irial-tr		resulting in death) Last	C. Due to (or as	a consequence	e of):								
8760,	death certificate be executed e attending physician and od for use as the burial-transit	hysiclan/Medical		d										
9	ertifica ling pl	Med	IF FEMALE:	20-1/			-							
Вох	eath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal deat		Ectopic pre						Date of deliver	ery Day Year
o.	at the de by the a tached	ysic	1 ☐ Yes 2 ☐No 9 ☐ Unknown	4□Pregnant a 9□Unknown	it time of death	2	Other (spe	эспу)		•				
s, P.	d de d	۵	Part II. Other significant conditions	contributing to death t	out not resulting	in the ur	nderlying ca	ause give	n in Part I.		23e. Did t	obacco use co	ntribute to ti	ne cause of death?
rds	w requires been sign should be	ed by									1 🗆 '	Yes 2 No	3 🔲 Prot	ably 4 Dunknown
of Vital Record	> 0 0	ompleted									24a. Was		. Were auto	psy findings available
H.	9 4 9											rmed? 2 No	death?	mpletion of cause of 2 No
/ita	ician: Th certificate ector, pag	BeC	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o			
) (Physician; r this certific ral director,	2	1 ☐ Yes 2 ☐ No	Hospital: 1 Inpati		-			4 🔲 Nui			dence 6 🗀 O		y)
	ding F h. After funera	ertification;	27. Manner of Death 1 SNatural 5 ☐ Pending	28a. Date of Inju (Month, Da	ay Year) 28b.	Time of Injury	M 28	Bc. Injury Work	at ? ′es 2.⊡1		8d. Describe I	now injury occi	urred	
Division	deat deat ctor: y the	ficat	2 Accident investigation 3 Suicide 6 Could not l	oe Diago of In	iurv - At home, f	farm, stre					8f. Location (Street and Nun	nber or Rura	I Route Number,
	in Sire	erti	4 ☐ Homicide determined	building, e	tc. (Specify)			, 011100			City or Tox	vn, State)		, read vanger,
	To the Hospital within 24 hours a To the Funeral Completely filled	edical C	29a. Certifier (Check only one) Certifying P	hysician: To the best miner: On the basis o and manner si	of examination a	ge, death nd/or inv	occurred a restigation,	at the time in my opi	e, date and inion, deat	d place, a h occurre	nd due to the	cause(s) and r date and place	nanner as si e, and due to	ated. the cause(s)
	To the Hos within 24 h To tha Fur completely	Me	29b. Signature and title of certifier	1			29c.	. License	number			29d. Date sign		
)			It van Ea	mond 1	ND			DOU	563	07		Octobe	1 24,	2006
^	0		30. Name address of person who	completed cause of	death (Item 23a)	(Type, I							,	
1	5A 5		J. Van Egmore	MD, Atla	whic Ge	ner	u Hos	pital	, 973	3 Hea	Hhnay	Drive, E	sevlin,	MD 21811
	Sta Registr	3	31. Date filed (Month Day, Year) OCT 2 6 2	006 32 degist	rar's Signature	do	alle)	•)			
	3,00	4 19	001 20 2			1								

008: 3/4/1927 000: 10/24/2006 0620 Margaret

State of Maryland / Department of Health and Mental Hygien [35484 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 8.34 PM LOVER 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Continuum Care Nursing Home Sykesville Carroll If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months 1 X M 2 □ F 78 209-20-5102 Director Jan. 9, 1928 Pennsylvania Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23s or 28s-f show the Medical Exercit errorat be notified at 1 X Yes 2 No Director Pa. Huntingdon Three Springs 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? P.O. Box 115 17264 U.S.A death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. hours after 1 X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 21 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiane. Important: If item 27 is marked other than any injury or other treumetin. Elementary/Secondary (0-12) College (1-4or 5+) Laborer Brickyard 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Emory Covert Mazie Madden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 115 Three Springs, Pa. 17264 Phyllis J. Covert (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place)
Old School Baptist 1 🛣 Burial 2 □ Cremation 3 □ Removal from State Oct. 28, 4 ☐ Donation 5 ☐ Other (Specify) Three Springs, Pa. Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 12525 Bradbury Ave. MO/4/4 J.L. Davis Funeral Home Smithsburg, Md. 21783 AVIS Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ameniscientic Priysician Cardavascular /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to tor as a consequence of Examiner law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760 attending physician by Physician/Medical the as IF FEMALE: esn. 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ŏ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Ninknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Wasan has autopsy performed? certificate 1 Yes 265KNo of Vital 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 | Inpatient Other: 2 1 Tes 210 No Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: After Division 5 Pending investigation Natural death. 1 Yes 2 Accident Director: 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier ical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pard MA HMOUT 19 12H-10+1 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 OCT Registrar

			1 - For State Registrar	State	of Maryla	nd / Depa	artmen rtificat			nd M	_	_	2006	35485
-	Physic /Medi Examir	cal	Decedent's Name (First, Middle, Maude Strickler 4a. Facility Name (If not institution,	Cottom	imber)		4b. City,	Town, or	Location of	Death	2. Date of De Month October	r 18	y Year , 2006	10:00 PM
	Funeral Director		206-32-8836	1	7. Age (In yr.	s. last birthday) Yrs.	If Under Months	Anna 1 Year	polis If Under 2 Hours		8. Date of Bird (Month, Da	A	nne Aru	
	within 72 hours after death with the Maryland ene. then "natural", or iteme 23a or 28a-f ehow ha Madical Examinar must be mullind at	Funeral Director	Usual Residence of Decedent 10a. State 10b. County Pennsylvania Fa 10e. Street and Number 126 Cottom Road	nyette	10c. (Dawson	10f. Zip	Code				_	izen of What C	10d. Inside City Limits 1 ★ Yes 2 No ountry?
-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentat Hygiene. Important: if item 27 is marked other then "natural", or iteme 23s or 28s-f show any injury or other treumatic event, the Madical Examirat must be multined at ance.	þ	11. Marital Status 1 Never Married 2 Marrie 3 WWidowed 4 Divorced 15. Decedent's	Armed For 1 Yes If Yes, Gi Year or E	2 🐧 No ve Dates:	16a. Dece	1 ☐ Yes	2 X No al Occupa	Specify:		ecify Yes or No Rican, etc.)		14. Race - Am Black, Whi Specify:	white
nd 21215-0036	e filed within 7: al Hygiene. I other then "n vent, Ine Madi	Be Completed	(Specify only highest Elementary/Secondary (0-12) 17. Father's Name (First, Middle, La	College (1 year	1-4or 5+)	life.	kind of wo DO NOT us memak	se retired,			ng) (First, Middle,		Home	
Baltimore, Maryland	and 2 should balth and Menti 127 is marked 17 treumatice	ToE	Fran 19a. Informant's Name/Relationship Doris C. Tatters							or Rura	aude Jan M <i>R</i> oute Numbe napolis	er, City o	or Town, State,	Zip Code)
Iltimore,	nit. Pages 1 a artment of He ortant: if item injury or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe 21. Signature of Funeral Service La	city)		Place of Dispo commetery, crer ottdale	Ceme	etery	10)/23	/2006	Sco	ttdale,	
			23a. Part 1. Enter the disease, or conshock, or heart failure. List or Immediate Cause (Final	omplications that	caused the dea		2973	Solor	nons I	sla	nd Rd.	Edge		MD 21037 Approximate Interval Between Onset and Death
3760,	Physician whysician and physician whysician and physician and physician and physician and physician with physician and physician with physician and physician with physician and physician with physician and physician with physician physician with physician physician with physician physi	lical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to	(or as a conse	equence of):	en c	Ŝ(T) ER	VCT1	Ton				V DAY 6 / 2006
P.O. Box 68	res thet the death certifica igned by tha ettending ph be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		ointh 2 ☐ Fe nant at time of	tal death 3	Ectopic pr						23d. Date of de Month	livery Day Year
Records, P	w requi	Completed by Pt	Part II. Other significant condition		eath but not re		nderlying c	ause give	n in Part I.	_	1 ☐ Y 24a. Wasa autop	es 2 an sv	No 3 ☐ P	o the cause of death? robably 4 Unknown utopsy findings available completion of cause of
	Physician: The la r this certificate has ral director, page 2	To Be Cor	25. Was case referred to medical examiner? 1 □ Yes 2 ⋈ No	Hospital: 1 🗆	Inpatient 2[☐ ER/Outpatien	t 3 DO	A Othe			performance 1 Personal Persona	2 A No		Development
Division of Vital	or Attending Physician: for death. Irector: After this certifican by the funeral director, p.	Certification:	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 6 Could no determine	t be 28e. Place	of Injury th, Day Year) of Injury - At Ing, etc. (Spec	28b. Time of Injury home, farm, str	М		at ? ′es 2 □ No	0 2	28d. Describe h	ow injur	y occurred d Number or R	ural Route Number,
۵	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical Cer	29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physician: To the	best of my kn	nowledge, death	occurred a vestigation,	at the time in my op	e, date and inion, death	place, a	and due to the o	alleb(e)	and manner as	s stated. e to the cause(s)
)	To t With To t com	×	29b. Signature and title of certifier 30. Name and address of person with	no completed caus	se of death (Ite	m 23a) (Type.	2	. License	5698			10	e signed (Mont	h, Day, Year)
	Sta Registr			ANE,	ogistrar's Sign	16/6 F	ORE.		DR/10	VE-	Anny	he Z	s m	20403

			1 - For State Registrar	* -	aryland / Depa		of H	ealth and	•		agible.	351.86
	Divi-		1. Decedent's Name (First, Middle, L.	ast)					2. Date of I		Year	3. Time of Death
	Physic /Medi Examii	cal	VIVIAN S. COM 4a. Facility Name (If not institution, gi			4b. City, To	own, or	Location of De	10	21 2	006 ounty of Death	11:30 AM
			CHESTER RIVER	MANOR		CHES					KENT	
	Funeral Director		218-16-9104	Sex 7. Age 1□ M 2XF	e (In yrs. last birthday) 7 8Yrs.		Year Days	If Under 24 H Hours N	in. (Month, L	Birth Da <i>y, Year)</i> .01928	9. Birth Cou	nplace (State or Foreign untry) [D
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation						10d. Inside City Limits
	Maryi f sho	Į.	MD KENT	Γ	CHESTER	TOWN						1 □ Yes 2 No
	r 28e	rec	10e. Street and Number		OHED TELL	10f. Zip C	ode			10g. Citizer	n of What Cou	untry?
	th wit	a	7485 POPLA	R AVE		21	620			US	A	
36	within 72 hours after death with the Maryland ene. then "naturel", or Items 23a or 28e-1 show I.s M-dical Examinar must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent B Armed Forces? 1 Yes 2 X If Yes, Give	lo l		nt of His y Cubar	spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or Nerto Rican, etc.)	1	Race - Amer Black, White pecify:BLA	e, etc.
Q	72 hours aft "naturel", or diral Exami	edk	15. Decedent's E	Year or Dates:	16a. Dece	dent's Usual	Occupa	tion		16b Kind	of Business/I	ndustry
21215-0036	hin 72	Completed	(Specify only highest gi Elementary/Secondary (0-12)	ade completed) College (1-4or 5	(Give	kind of work DO NOT use	done di	uring most of a	vorking	Too. Italia	or businessir	ridustry
21	filed with Hygiene. Ither thei	E C	11th	College (1-4015	LI	NE WO	RKĘ	R		Blac	k&Dec	ker
nd	be file ital Hy id oth eveni	Be	17. Father's Name (First, Middle, Las	1)				18. Mother's N	lame (First, Midd	le, <i>Maiden S</i> u	mame)	
Ŋ	should be filed within nd Mental Hygiene. I marked other then umetic event, It e M	70	IVY JOHNSON 19a. Informant's Name/Relationship	(Time Brief)	105 14 18		21		A BESSI			
Maryland	S is a		PAMELA BROWN-		1				Rural Route Num			
	s 1 and 3 if Health item 27 other tr		20a. Method of Disposition		20b. Place of Dispo	sition (Name	of	L Ave	. Chest	20c. Locat	n MD ion - City or T	Z16ZU Town, State
E G	0°= 5		1 Maurial 2 □ Cremation 3 (1 □ Donation 5 □ Other (Special		JANES		er piace	ı	/28/06	Chog	tetow	n MD
Baltimore,	artmartministra	1	21. Signatule of Funeral Service Lice		22	2. Name and	Address	of Facility Z	nnoth	Walles	r Fun	n, mu
<u> </u>	Per Pep Final		Joyce O. U	Jalley (W00026) 22	Servi	ce .	821 W	St. A	nnapo:	lis,	MD 21401
100	Pnysician /Medical Examiner	e.	23a/Part1. Enter the disease, or con mock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a	the death. Do not entire. a consequence of):	er the mode		100	incor respiratory			Approximate Interval Between Onset and Death
68760,	The law requires that the death certificate be executed to has been signed by the attending physician and rage 2 should be detached for use as the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С.	a consequence of):							
.O. Box	at the death certific by the attending p tached for use as I	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal death 3 ☐	Ectopic preg Other (spec				23d	. Date of deliv Month	very Day Year
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions	contributing to death bu	_	nderlying cau	se giver	n in Part I.		tobacco use		the cause of death?
Records,	(G CT	Completed			/				peri	s an 2. opsy formed?	prior to co death?	opsy findings available ompletion of cause of
Vital	Physicien: T this certificat ral director, pa	Be (25. Was case referred to medical examiner?				-		eath (Check only	one)		
of	Sop	2	1 Yes 2 10 No 27. Manner of Death		nt 2 ER/Outpatien	_	Other	4 Priursing	Home 5 Res			fy)
O	ing After	tlon	1 Pending 5 Pending	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury	M 280	Work?	at es 2⊡No	28d. Describe	now injury oc	curred	
5	Atten er deat ector: by the	ertification;	2 Accident investigation 3 Suicide 6 Could not be determined	De Diagnotiniu	ry - At home, farm, str. . (Specify)			33 2 110		(Street and No	umber or Run	al Route Number,
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	edical C	29a. Certifier 1 Descritying Pl (Check only one) 2 Medical Example	nysician: To the best o miner: On the basis of and manner stat	examination and/or inv	occurred at restigation, in	the time	, date and pla nion, death oc	ce, and due to the curred at the time	cause(s) and , date and pla	i manner as s ce, and due t	stated. o the cause(s)
	To the I within 2 To the I complet	×	29b. Signature and title of certifier			29c. L	icense	number			gned (Month,	Day, Year)
)	6		> 164 lllun	J WD		2	1)2,	1313		10/2	3/06	
			30. Name and address of person who	completed cause of de	eath (Item 23a) (Type,	Print)						
	Tm		KIN K WUN, MD	415 Wash	ington A	ve Ch	est	ertow	n, Mary	land,	MD 2	21620
	Sta Registr		31. Date filed (Month, Day, Year) OCT 2 3	32. Registra		South	0					

	For State Registrar	State of Maryland	/ Department of I			2006	351.87
	Decedent's Name (First, Middle, L.	ast)		2. Date	of Death		3. Time of Death
Physician	Robert Eugen	e Crowley		Mont	bec 20		1650 M
/Medical - Examiner	4a. Facility Name (If not institution, g		4b. City, Town, o	r Location of Death		County of Death	
	DORCHESTER GE	NERAL HOSPITA	AL CAMBA	IDGE		DORCHE	STER
neral	Social Security Number 6.	Sex 7. Age (In yrs. las		If Under 24 Hrs. 8. Date Hours Min. (Mon	of Birth	9. Birth	place (State or Foreign ntry)
I 1	221-18-6859 Usual Residence of Decedent	12 M 2□F 75	Yrs.	Sep	of Birth h, Day, Year) t. 10,	1931 De	l'aware
4	10a. State 10b. County		Town or Location				10d. Inside City Limits
et o	Maryland Dorche	ster	East Ne	w Market			1 Tes 2 No
	10e. Street and Number		10f. Zip Code		10g. Citi	zen of What Cou	ntry?
edical Examinar must be leted by Funeral I	3318 Landrum Dri	ve	21	631		US	A
릴	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of I If Yes, specify Cub	lispanic Origin? (Specify Yes an, Mexican, Puerto Rican, et	or No-	 14. Race - Ameri Black, White 	
Y.	1 Never Married 2 Married	If Voc Civo	1 7 Yes 200			Specify:	
d by	3 Widowed 4 Divorced	Year or Dates: Korean					White
To Be Completed	15. Decedent's f (Specify only highest g	Education rade completed)	16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	ation during most of working	16b. Ki	nd of Business/Ir	ndustry
를	Elementary/Secondary (0-12)	College (1-4or 5+)					
once. To Be Comp	12	3	Manageme			Groce	ry
Be	17. Father's Name (First, Middle, Las	:()		18. Mother's Name (First, N			
입	Frank Crowley			Mabel	Loflar	nd 	
4 W	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing Address (Street	and Number or Rural Route !	lumber, City o	r Town, State, Zij	o Code)
	<u>Sheila Crowley No</u>		2502 Legacy C	ourt, Cambrid	e MD	21613	
	20a. Method of Disposition	20b. Plac	ce of Disposition (Name of netery, crematory or other pla	Date Date	20c. Lo	cation - City or T	own, State
	1 Marial 2 ☐ Cremation 3 6 4 ☐ Donation 5 ☐ Other (Spec	Puetito at Itolii 2000		erv 10/26/20	O6 Hur	lock, M)
	21. Signature of Funeral Service Lice						
Succession	Maleren Hins	1 - Drawing	Curran-Br	ss of Facility OMWell Funera St., Cambridge	L Home,	P.A.	
	2. Part 1. Enter the disease, or cor	mplications that by sed the death, y one cause on each line.				.1013	Approximate
	shock, or heart fall. List onfi Immediate Cause (Final	y one cause on each line.	1				Interval Between Onset and Death
n	disease or condition resulting in death)	a DOSTONST	ructive	[nevmon	9		
		Due to (or as a consequer	nce of):	_			
-	Sequentially list conditions,	b. Due to (or as a consequer	Cance				
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conspequer	ice oi).				
xan	that initiated events resulting in death) Last	c Due to (or as a consequer	nce of):				
calE		500 10 (01 23 2 0011504201	100 07).				
	•	d					
Me	IF FEMALE:						
an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnance 1 ☐ Live birth 2 ☐ Fetal de	eath 3 Ectopic pregnancy	,	2	23d. Date of deliv Month	ery Day Year
O		4☐Pregnant at time of deat	th 5 Other (specify)		1	MOUTH	
go	1 Yes 2 No	9□ Unknown	-20(4)				Day 10ai
Physi	9 □ Unknown						
by Physician/Medi				en in Part I. 23e.		1	he cause of death?
ed by Physi	9 □ Unknown			en in Part I. 23e.	Did tobacco u	1	
pleted by Physi	9 □ Unknown				1 ☐ Yes 2[••••••••••••••••••••••••••••••••••••	No 3 Prol	he cause of death? pably 4 □Unknown posy findings available
ompleted by Physi	9 □ Unknown			24a.	1 ☐ Yes 2 [: Was an autopsy performed?	24b. Were auto	he cause of death? bably 4 Unknown bopsy findings available mpletion of cause of
Completed by	9 □ Unknown Part II. Other significant conditions			24a.	1 Yes 2 [Was an autopsy performed? ∕es 2 No	No 3 Prof	he cause of death? bably 4 Unknown bopsy findings available mpletion of cause of
Be Completed by	9 □ Unknown Part II. Other significant conditions 25. Was case referred to medical examiner?	contributing to death but not resulting	ng in the underlying cause giv	24a. 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Was an autopsy performed? /es a No	24b. Were autoprior to codeath?	he cause of death? bably 4 □Unknown bopsy findings available mpletion of cause of 2 □ □ □ □
To Be Completed by	9 □ Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 □ Yes 22 № 0	contributing to death but not resulting to death	ng in the underlying cause given the underlying th	24a. 1 1 26. Place of Death Check er: 4 Nursing Home 5	1 ☐ Yes 2 ☐ Was an autopsy performed? Yes 2 ☐ No only one ☐	24b. Were auto prior to co death? 1 Yes	he cause of death? bably 4 □Unknown bopsy findings available mpletion of cause of 2 □ No
To Be Completed by	9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 1 vs 2 2 No 27. Manner of Death 1 New Natural 5 Pending	contributing to death but not resulting to death	ng in the underlying cause give the second of the underlying cause give the underlying cause giv	24a. 1	Was an autopsy performed? /es a No	24b. Were auto prior to co death? 1 Yes	he cause of death? bably 4 □Unknown bopsy findings available mpletion of cause of 2 □ □ □ □
To Be Completed by	9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 Pro 27. Manner of Death 1 Autural 5 Pending investigatic investigatic 5 Could not 6 Could not	Contributing to death but not resulting to death	NOutpatient 3 DOA Other Injury Mo	24a. 1	Mas an autopsy performed? (ves 200 No only one) Residence 6 Residence 6	24b. Were autoprior to code attraction of the	he cause of death? bably 4 Unknown bopsy findings available mpletion of cause of 2000
ion; To Be Completed by	9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 Plo 27. Manner of Death 1 Part Autural 5 Pending investigation	Contributing to death but not resulting to death	NOutpatient 3 DOA Other Injury Mo	24a. 1 26. Place of Death Check er: 4 Nursing Home 5 28d. Desc k? Yes 2 No 28f. Loca	Mas an autopsy performed? (ves 200 No only one) Residence 6 Residence 6	24b. Were autoprior to codeath? 1	he cause of death? bably 4 □Unknown bopsy findings available mpletion of cause of 2 □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □
ion; To Be Completed by	9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Ves 2 No 27. Manner of Death 1 Natural investigating investigating investigating determined 2 Nocident determined 29a. Certifier Certifying P	contributing to death but not resulting to death but not resulting to death but not resulting to death but not resulting patient 2 ER 28a. Date of Injury 28a. Place of Injury - At home building, etc. (Specify)	NOutpatient 3 DOA Ott Not Injury M 28c. Injury M 1 Repair of Injury M 1	24a. 26. Place of Death Check er: 4 \(\) Nursing Home 5 \(\) y at k? Yes 2 \(\) No 28f. Local City (Town, State,	24b. Were autoprior to code at the code at	he cause of death? bably 4 Unknown posy findings available impletion of cause of 2000
Certification; To Be Completed by	9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Ves 2 No 27. Manner of Death 1 Natural investigating investigating investigating determined 2 Nocident determined 29a. Certifier Certifying P	Hospital: 1 patient 2 ER 28a. Date of Injury (Month, Day Year) 28b. Place of Injury - At home	NOutpatient 3 DOA Ott Not Injury M 28c. Injury M 1 Repair of Injury M 1	24a. 26. Place of Death Check er: 4 \(\) Nursing Home 5 \(\) y at k? Yes 2 \(\) No 28f. Local City (Town, State,	24b. Were autoprior to code at the code at	he cause of death? bably 4 Unknown posy findings available impletion of cause of 2000
edical Certification: To Be Completed by	9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigate 3 Suicide 6 Could not 1 determined 29a. Certifier (Check only 2 Medical Examined)	Hospital: 1 patient 2 ER 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home building, etc. (Specify) 29 hysicien: To the best of my knowle	NOutpatient 3 DOA Ott Not Injury M 28c. Injury M 1 Repair of Injury M 1	24a. 26. Place of Death Check er: 4 \sum \text{Nursing Home} 5 \sum y at k? Yes 2 \sum \text{No} 28f. Loca City of the check of the c	Was an autopsy performed? (es 20 No only one) Residence furibe how injury ion (Street and or Town, State, on the cause(s) time, date and	24b. Were autoprior to code at the code at	he cause of death? bably 4 Unknown posy findings available impletion of cause of 2000
ion; To Be Completed by	9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigate 3 Suicide 6 Could not 4 Homicide 29a. Certifier (Check only one)	Hospital: 1 patient 2 ER 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home building, etc. (Specify) 29 hysicien: To the best of my knowle	NOutpatient 3 DOA Ottoring to DOA Injury M 1 DOA In	24a. 26. Place of Death Check er: 4 \sum \text{Nursing Home} 5 \sum y at k? Yes 2 \sum \text{No} 28f. Loca City of the check of the c	Was an autopsy performed? (es 20 No only one) Residence furibe how injury ion (Street and or Town, State, on the cause(s) time, date and	24b. Were autoprior to codeath? 1 Yes 5 Other (Special of Number or Rural and manner as splace, and due to	he cause of death? bably 4 Unknown posy findings available impletion of cause of 2000
Medical Certification: To Be Completed by	9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigates investigates of Could not 4 Homicide 29a. Certifier (Check only one) 29b. Signater and title of certifier Could not 1 Check only one)	Hospital: 1 patient 2 ER 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home building, etc. (Specify) Physicien: To the best of my knowle and ryanher stated.	VOutpatient 3 DOA Ott Bb. Time of Injury M 1 Be, farm, street, factory, office adge, death occurred at the time and/or investigation, in my of the street of	24a. 26. Place of Death Check er: 4 \sum \text{Nursing Home} 5 \sum y at k? Yes 2 \sum \text{No} 28f. Loca City of the check of the c	Was an autopsy performed? (es 20 No only one) Residence furibe how injury ion (Street and or Town, State, on the cause(s) time, date and	24b. Were autoprior to codeath? 1 Yes 5 Other (Special of Number or Rural and manner as splace, and due to	he cause of death? bably 4 Unknown posy findings available impletion of cause of 2000
Medical Certification: To Be Completed by	9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigate 3 Suicide 6 Could not 4 Homicide 29a. Certifier (Check only one)	Hospital: 1 patient 2 ER 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home building, etc. (Specify) Physicien: To the best of my knowle and ryanher stated.	VOutpatient 3 DOA Ott Bb. Time of Injury M 1 Be, farm, street, factory, office adge, death occurred at the time and/or investigation, in my of the street of	24a. 26. Place of Death Check er: 4 \sum \text{Nursing Home} 5 \sum y at k? Yes 2 \sum \text{No} 28f. Loca City of the check of the c	Was an autopsy performed? (es 20 No only one) Residence furibe how injury ion (Street and or Town, State, on the cause(s) time, date and	24b. Were autoprior to codeath? 1 Yes 5 Other (Special of Number or Rural and manner as splace, and due to	he cause of death? pably 4 Unknown posy findings available impletion of cause of 200 200 200 200 200 200 200 2

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Mary		rtificate of	Death		30g. 2 . 0 0	6	35488
	Physician	1. Decedent's Name (First, Middle, Las	JORDAN	McMIIRRY	CARR	2	Dete of Dee Month	eth	Year	3. Time of Death
	/Medical			TCHOKK1	CARR		ctobe:	r 31 20	006	7:15 PM
	Examiner	4a Fecility Neme (If not institution, given 114 C Rouzer				4b. City, Town, or Local		,		k County
	Funeral	5. Social Security Number 6. S		yrs. last birthday)	If Under 1 Year		. Date of Birth (Month, Dey			ece (Stete or Foreign
- 1	Director	216-46-5636	□ M 2X0 F	88 Yrs.	Months Days	Hours Min.	(Month, De) Feb.	12 1918	Count Te	nnessee
	D .	Usuel Residence of Decedent 10a. State 10b. County	100	c. City, Town or Lo	cation				10	Od. Inside City Limits
	Aanyle fahor		erick	Thurmo					10	1 TyYes 2 □ No
	the N	10e. Street end Number	01101	111011110	10f. Zip Code			10g. Citizen of Wh	hat Count	trv?
	offer deeth with the Ma r Nerse 23s or 28s-1 s riner must be nutified Funeral Director	114 C Rouzer	Lane		2178	38		United		•
	deetil	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U,S. 13.	Was Decedent of I	Hispanic Origin? (Speci pan, Mexican, Puerto Ri	fy Yes or No-	14. Race	- America	
Baltimore Maryland 21215-0036	filled within 72 hours effect deeth with the Maryland Hydrines. ther times "natural", or items 23s or 28s-1 show but, the Medical Examiner must be notified at the Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 阡 Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yas 2 🗓 No				whi	
7.	natural, natural in interest i	15. Decedent's Ed (Specify only highest gre	lucation de completed)	16a. Dece (Give	dent's Usuel Occu kind of work done	pation during most of working ed)		16b. Kind of Bus	iness/Inde	ustry
5	uld be filed within 72 hot what I Highen "natural rice orber then "natural rice event, the Medical To Be Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		nemaker	•		own ho	ome	
2	nould be filed to what the state over the To Be Co	17. Fether's Neme (First, Middle, Last)				18. Mother's Name (/	First, Middle,	Maiden Surname)	
<u></u>	should be ind Mental in marked of urnatic eve	Frank E. McMu	rry			Frances	Jord	an		
2	2 sho and h is ma	19a. Informant's Name/Relationship (7	**			t and Number or Rurel F				
2	1 and 2 Haalth em 27 i	Rna Carr / da		114		zer Lane	_	mont, I		
morr	Department of Health and Sehould be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the Mates. To Be Compi	20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State	ob. Place of Dispo cemetery, crer New St.		n's Cem	. 77	20c.Location - C Emmitsb	•	
=======================================	Departm Mportar any inju	21. Signature of Funeral Service Licen	·	22	. Nama end Addre	ess of Facility Ski	es Fi	uneral	Home	9
C	I SEES	Alun C.	Purur			Main St. 1				21727
	×	23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the	deeth. Do not ent	er the mode of dyi	ing, such as cardiac or r	espiratory arr	rest,	1	Approximate Interval Between
	Physician		6 .	1	100	+ 1	۹.			Onset and Death
_	/Medical Examiner	Immediate Ceuse (Final diseese or condition resulting in death)	· Lson	hage	el Ul	shuct	is_			Swhs
	p p		Esalati	to (or es a consec	uence of):	1 Pati	0	Buch		· Y.
261	outed and ransit	Sequentially list conditions	b. Due	to (or as e conseq	uence of): X	ng race	Wow	s Krayo	My	o lys
0	ifficate be assecuted g physicien and es the bunal-transit	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (clissass or injury that initiated events resulting in death) Last		0	0				9	V
68760	cate b	that initiated events resulting in death) Last	Due	to (or as a conseq	uence of):					
	= 0.0	L	d						i	
Ä	d for u	Pag II. Other significant conditions co	ontributing to death but not	reculting in the w	adartwina cauca ai	ven in Part I	23h Did 16	nhacoo uso conti	ribute to	the cause of death?
0	t tha c by the tache	AH . A . O .	4	1 lessatting in the di	derlying cause gr		1 □ Y	10		ably 4 Unknown
νi.	gned be dar	umigration	our con	diova	scuis-	Disease				· _
Sord	require been si should	Chronic Ole	structure	Hulm	Dular	1 with	24a. Was e	en aut psy med?	avai	re autopsy findings ilable prior to apletion of cause
$\mathcal{C}_{\mathcal{S}}$ Division of Vital Records. P.O. Box	To the Hospital or Attending Physician: The law requires that the deeth cerwithin 24 hours after death. To the Funeral Director: After this certificata has been signed by the ettendin completely filled in by the funeral director, page 2 should be detached for use Medical Certification: To Be Completed by Physician/N				nyr	oxis	1 🗆 Y	es 2 🔀 No		eath? Yes 2□ No
/ita	clan: entifica ector, Be (25. Was case referred to medical examiner?	11		0,	26. Place of Death (6				
Ę,	Physic this or ral dire	1 ☐ Yes 2 🔀 No 27. Manner of Deeth		2 ER/Outpatien 28b. Time of	t 3 DOA	her: 4 Nursing Home		ence 6 Other)
5	ding h. After funa	1 XNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Dey Yea	ir) Injury	Wo	rk?]Yes 2□No	J. Describe III	ow injury occurred	1	
N. S.	Atten ector: by the	3 Suicide 6 Could not be determined		At home, farm, str	eet, factory, office	281	Location (Si	treet and Number	or Rura!	Route Number,
	tal or rs afte al Dir led in	4 Litomole	building, etc. (3)				- City Of TOWN	n, State)		
	of the Hospital or Attending Pithin 24 hours after death. The Funeral Director: After the mipletely filled in by the funeral Medical Certification:	29a. Certifier 1 X Certifying Phyone 2 Medical Example 2	rsician: To the best of my iner: On the basis of exar and menner stated.	knowledge, death hination end/or inv	occurred et the ti restigation, in my o	me, date end place, and opinion, death occurred	due to the cathe the time, d	ause(s) and manr late and place, an	ner as sta id due to t	ited. the ceuse(s)
	To the To the Somple	29b. Signature and title of certifier	VII		29c. Licens	se number	_ 2	29d. Date signed ((Month, D	Dey, Year)
			Clat	aud	WI	118705		1111	106	0
	\cap	30. Name end address of person who		(Item 23a) (Type,					-	
	V	Alan L. Carro			. Seton	Ave. E	Cmmits	burg, l	Md.	21727
į	State Registrar	31. Date filed (Month, Day, Year) NOV 0 9 2	32. Registrer's S	ignature	1 - 10 -					
D	HMH 16 Rev 6/95	1404 0 3 7	UUU FEERE	J. J.	DEALS!					
				ORI	GINAL.					

			1 - State of State of Registrar		Department of Certificate	of Health and		iene _{99. No} 2 0 0 6	35489
			Decedent's Name (First, Middle, Last)				2. Date of Deat	th	3. Time of Death
	Physici /Medio		Bethy Rodriguez Carnero				October	$21^{\text{pay}}, 200^{\text{Year}}$	9:00 Am
*	Examir		4a. Facility Name (If not institution, give street and numb	xer)	4b. City, Tov	m, or Location of Dea	th	4c. County of Death	1
			1000 Heather Ridge Drive			erick	T = 10.11	Frederic	
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ☑ F 7 095-22-5243 Usual Residence of Decedent	. Age (In yrs. last birt		ear If Under 24 Hr. ays Hours Min		Year) 9. Birth Cou Puer	place (State or Foreign intry) to Rico
	ow ow		10a. State 10b. County	10c. City, Towr	n or Location				10d. Inside City Limits
	Man,	tor	Maryland Frederick	Fred	lerick				1 🗓 Yes 2 🗆 No
	th the	Directo	10e. Street and Number		10f. Zip Co	de	10	0g. Citizen of What Cou	intry?
	ath w	rai	1000 Heather Ridge Dr., A			702		United Sta	tes
920	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23s or 28s-f show aumatic event, its Medical Exatrateur must be notified at	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Yes 2 If Yes, Give Year or Dat	⊠No		of Hispanic Origin? (:Cuban, Mexican, Pue No Specify: $Pu\epsilon$		14. Race - Ameri Black, White 1 Specify: Whi	, etc.
ğ	72 hor	ted	15. Decedent's Education (Specify only highest grade completed)	16a.	Decedent's Usual O	ccupation	1	16b. Kind of Business/I	ndustry
2	ithin Jen	Completed	Elementary/Secondary (0-12) College (1-4			one during most of wo atired)	Jiking		
2	fled w tygier her th		17. Father's Name (First, Middle, Last)	5	Secretary	10 14-14-1-1		Shippin	g
Maryland 21215-0036	Mental H Merked of arked of	To Be	Jose Rodriguez				rme (First, Middle, M Perez Fra		
	es 1 and 2 should b of Health and Ment of Item 27 is marked ir other traumatic e		19a. Informant's Name/Relationship (Type, Print) Miriam Velarde / Daughter					City or Town, State, Zi	,
Baltimore,	permit. Pages 1 a Department of He Important: If Item eny injury or oth		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ Removal from St 4 □ Donation 5 □ Other (Specify)	ale	Disposition (Name of community, crematory or other	10000	ber 25,	20c. Location - City or T	
턡	mit. F sertme sortar injur		21. Signature of Funeral Service Licensee	Restna	ven Crema		:006 <u>F</u>	rederick, l Skkot Cod	Maryland
ď	Ped in g		1 116		9501 Cat	n Funeral octin Mtn.	Hwy. Fre	derick, MD	21701
يتأنين	Physician		23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only the cause on each immediate Cause (Final disease or condition	used the death. Do not line. ac Dysrhyt		dying, such as cardia	c or respiratory arre	ist,	Approximate Interval Between Onset and Death
	/Medical Examiner			as a consequence of	of):				
	nsit	miner	cause. Enter Underlying Cause (Disease or injury	ав а сопведненое с	of):				
, 20,	cate be executed physicien and the burial-transit	I Examin	triat initiated events	as a consequence of	of):				
68760,	icate b physic	dical	d.						
P.O. Box (law requires that the death certificate be executed as been signed by the ettending physicien and 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months?	me of pregnancy h 2 ∏Fetal death nt at time of death m	3 □Ectopic pregnt 5 □ Other (specify	ancy		23d. Date of deliv Month	ery Day Year
	that the by detail		Part II. Other significant conditions contributing to dea	th but not resulting in	the underlying cause	given in Part I.	23e. Did toba	acco use contribute to t	he cause of death?
Spuc	w requires been sign should be	ted by	Congestive Heart Failure				1 □ Ye	s 2□No 3□Proi	oably 4 🖾 Unknown
Vital Records,	The ste h	Completed					24a. Was an autopsy perform	prior to co ned? death?	opsy findings available impletion of cause of
II a	ilcian: Th certificete rector, pag	Be (25. Was case referred to medical examiner?				ath (Check only one	a)	
5	Physician: r this certifice ral director, p	ဥ	1 ☐ Yes 2 反 No Hospital: 1 ☐ Ing	patient 2 ER/Out	tpatient 3 DOA	Other: 4 Nursing !		nce 6 Other (Special	(y)
<u></u>	ding f h. After funer	ion	2 Material 3 Li Groung		njury	njury at Work? 1 □ Yes 2 □ No	28d. Describe how	w injury occurred	
	r Attsn ter deat irector: I by the	Certification:	2 Accident investigation 3 Surcide 6 Could not be 4 Homicide determined 28e. Place of building	Injury - At home, far , etc. (Specify)			28f. Location (Stre City or Town,	eet and Number or Rura , State)	al Route Number,
_	To the Hospital of within 24 hours af To the Funeral D completely filled in	edicai C	29a. Certifier (Check only one) 1 Certifying Physicien: To the base of the b	is of examination and	, death occurred at th For investigation, in r	e time, date and place	e, and due to the cau urred at the time, dat	use(s) and manner as s te and place, and due t	tated.
	o the o the omple	Med	one) and manner 29b. Signature and title of certifier	Stated.		ense number		d. Date signed (Month,	
ì.	- s + ō		> M. 11/1/11	1)		41778		tober 21, 2	
	6		30. Name and address of person who completed cause	of death (Item 23a) (7/5/0	106	CODEL 21, 2	-000
	')		MICHARL W COSTELLO 156.	9 URSSUM	TULN PILE	FNOENKU.	MO 21702	L	
	Sta Registr		MICHAEL W Co 175 UG 156. 31. Date filed (Month, Day, Year) OCT. 2 4 2005	istrar's Signature	Sports				

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar			C	ertific	ate of	Death		R	eg. No.				
			1. Decedent's Name (First, Midd	lle, Last)		_			***************************************		2. Date of Dea				3. Time of	Death
	Physic /Medi		CALVIN LEE CRI	USE							Month OCTOBER	Day 21		өаr 06	8:35	\mathbf{P}^M
	Examir		4a. Facility Name (If not institution		mber)		4b. 0	Cily, Town, o	r Location o				County of			
			1803 CHESTER I	DRIVE			СН	ESTER				OUF	EN A	NNE *	S	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	. last birthda		nder 1 Year	If Under Hours		8. Date of Birth (Month, Day			Birthpl	ace (State or	r Foreign
	Director	ŀ	239-34-4790	1 X M 2□F	78	Yrs.	MOII	Ins Days	Hours	Min.	10/25/1	927	N	Count [C	ry)	
	p ,		Usual Residence of Decedent													
	aryla shov	_	10a. State 10b. County	<i>(</i>	10c. C	ity, Town or	Location							10	0d. Inside Cit	
	Ba-f	5	MD QUEEN	ANNE'S	СН	ESTER									1 🗌 Yes	2 X 1No
	in th	Director	10e. Street and Number				10f	. Zip Code			1	0g. Citiz	zen of Wha	at Coun	iry?	
	ath with the Marylan 23a or 28a-f show		1803 CHESTER DI	RIVE			2	1619			U	SA				
	iter dea	Funeral	11. Marital Status	12. Was Dec Armed Fo	edent Ever in U	J.S. 13	. Was D	ecedent of H specify Cuba	lispanic Ori	gin? (Spe	cify Yes or No-	1	4. Race -	America White, e		
ŏ	E 6 8		1 ☐ Never Married 2 🔀 Mar	rned 1 XYes If Yes, Gi	2 □ No			s 2 X No	Specify:	,				vviiito, c	to.	
3-003a	d within 72 hours jiene r then "natural", ine Medical Ex-	d by	3 ☐ Widowed 4 ☐ Divorce	Year or E	ates:								Specify:	WHI:	ГE	
ก็	72 hours "natural",	Completed	15. Deceder (Specify only highe	nt's Education est grade completed)		(Giv	e kind o	Usual Occup f work done	durina mosi	t of working	ng	16b. Kir	nd of Busin	ness/Ind	ustry	
V	within ene. then "	ם	Elementary/Secondary (0-12)	College (1-4or 5+)			Tuse retired	,							
N	Hygie ther ther ther ther ther	S	6			LONG	DIS	TANCE					TON !	ruc	KING	
		Be	17. Father's Name (First, Middle,	Last)					18. Mothe	r's Name	(First, Middle, I	Maiden :	Sumame)			
<u> </u>	should be nd Mental marked imatic ev	P	COY CRUSE						LUCIL							
ō	~ 6 = 5		19a. Informant's Name/Relation	ship (Type, Print)		19b. Ma	ling Add	ress (Street	and Numbe	er or Rural	Route Number	, City or	Town, Sta	ite, Zip	Code)	
2 "`	1 and Health sem 27		JACQUELINE CRUS	SE / WIFE					RIVE,	CHE	STER, M	D 21	619			
ore	es 1 a of Hea if item ir othe		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 DRamoval from		Place of Disp cemetery, cr	osition (ematory	(Name of or other plac	(9)	Da	ate	20c. Loc	cation - Cit	y or Tov	vn, State	
Ξ	Pag ment ant: i	1	4 Donation 5 Other (S			IGSLEY	CEM	ETERY	1	0/25	/2006	CHES	STER,	MD		
	permit. Pages. Depertment of h Important: if ite any injury or of		21. Signature of Funeral Service	Licensee	7		22. Nam	e and Addre	ss of Facilit	v		AM T	TOTED A	AT TI	OMP T	
0	80 E 2 8	8	LX M	DR	16		106	SHAMRO	OCK RD) • • C	& NEWN. HESTER,	AMD MD	21619	9 9 T H	UME, P	'.A.
			23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that of	aused the dea										Approximate Interval Betw	
	Physician		Immediate Cause (Final disease or condition			200								0	Onset and D	eath
	/Medical		resulting in death)	Due to	(or as a consec	dence of):	CIL	CY						- 2	11101	17/13
	Examiner															
		Jer	Sequentially list conditions,	Due to	(of as a consec	quanca of).										
	executed in and ial-transit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	S .												
s		Exa	resulting in death) Last	Due to	(or as a consec	quence of):										
SO,	certificate be iding physicia se as the bur	edical		d												
0	tifical g phy as th	ed		1												
5	n cer andin use	N/M	IF FEMALE: 23b. Was decedent pregnant		come of pregn		O=					2:	3d. Date of	f deliver	У	
0	deati	lcia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregr	oirth 2 ☐ Feta nant at time of c			ic pregnancy (specify)					Month	[Day Ye	ear
;	by the	Physician	9 Unknown	9□ Unkn	own											
	s tha	by P	Part II. Other significant conditi	ons contributing to d	eath but not res	sulting in the	underlyir	ng cause give	en in Part I.		23e. Did tob	acco us	e contribu	te to the	cause of de	ath?
colds,	n sig										1 10/Ye	s 2 🗆]No 3[Proba	bly 4 □Ur	nknown
3	w rec	Completed									24a. Was a	,]	24b War	o auton	sy findings a	wallable
ב כ	he ta e has ige 2	Ē						_			autops	y	prior	to com	pletion of car	use of
<u> </u>	n: T ficet or, pa	ပိ	25 Was sone referred to madica								1 ☐ Yes 2			Yes 2	!□ No	
=	sicie certi	o Be	25. Was case referred to medica examiner?	Hospital:			17.7	Othe			Check only on					
5	Phys r this ral di	 	1 Yes 2 No	1 🗀 1		ER/Outpation 28b. Time		DOA	4 🔲 INUI		e 5 Reside			Specify)		
5	ding P. After fune	io	1 Natural 5 ☐ Pendir	'9	of Injury th, Day Year)	Injury	M	28c. Injury Work	val ∢? Yes 2 □ N		8d. Describe ho	w injury	occurred			
2	deati deati ctor: / the	ica	3 ☐ Suicide 6 ☐ Could	not be 390 Place	of laiuns. At h	omo form o			163 2 1		06 Lagatina /Ct		I A /	. 0	D	
<u> </u>	or A after Direct in by	Certification:	4 Homicide determ	nined 200. Flace buildi	of Injury - At h ng, etc. <i>(Specil</i>	fy)	treet, tac	ctory, office		20	8f. Location (St. City or Town		Number o	r Rurai	Houte Numb	e <i>r</i> ,
-	pital iurs e aret		29a. Certifier 1 Certifyin													
	Hos 24 ho Fun fely i	edical	(Check only 2 Medical one)	ng Physician: To the Exeminar: On the ba	asis of examina	ation and/or i	ith occur nvestiga	red at the tim tion, in my or	ne, date and pinion, deat	d place, ar h occurre	nd due to the ca d at the time, da	iuse(s) a ite and p	and manne place, and	r as sta due to t	ted. he cause(s)	
	To the Hospital or Attending Physicien: The law requires that the death within 24 hours stell death within 24 hours stell death. To the Eurorei Director: After this certificate has been signed by the etten completely filled in by the funeral director, page 2 should be detached for u	Med	29b. Signature and title of certifie	and man	ner stated.		- T	29c. License					signed (N			
	F. ₹ F. 8		250. Signature di Amilio di contro	1				230. Elberise	250	67	2:	ou. Dale	Signey (N	3/	06	
			1)1100	CINV				V.	118	0 /		(1/2	1	J. ,	
			30. Name and a ss of person	who completed caus	e of death (Iter	п 23а) (Туре	, Print)	N	_	100			1			
	-		29466 P	in tail	Dr. 7	#5		Davi	d 5,	mith	1					
	Sta		31. Date filed (Month, Day, Year)	32. R	egiatrar's Signa	ature	1	. M		·	-					
	Registr		_OCT &	4 ZUUb	Status	15.	400	all had	-							
MC	MH 17 Rev 1/20	001					-									

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Physician Michaila Louise Disney October 0 21, 2006 5:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 1634 Fairhill Dr. Anne Arundel Edgewater If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth Month, Day, Yea 10/2/1996 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 XF 10 Maryland Director <u>212-49-3086</u> Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f ehow Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Heelth and Mental Hygiene.
ant: If Item 27 te marked other then "naturel", or Items 23s or 28s-f ehov ury or other treumatic event, the Madical Examinar must be notified at 1 Yes 2 No Directo Maryland Anne Arundel Edgewater 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1634 Fairhill Drive 21037 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Katherine Packett Paul Disney ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Disney/ Father 1634 Fairhill Drive, Edgewater, MD 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages:
Department of H
Important: If Its
eny injury or ot
once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Kalas Crematory Edgewater, MD 4 □ Donation 5 □ Other (Specify) 10/24/06 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home Me mis 2973 Solomons Island Rd. Edgewater, MD 21037 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** P horv +1 /Medical Due to (or as a consequence of) Examiner Chromos obni Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the attending physicien and the for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy the funeral director, page 2 should be detached for Month in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 1 Yes 2 No 1 Yes 2 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Nasidence 6 Other (Specify) ၉ 1 ☐ Yes 2 🔀 No 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after deat Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) nes mi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MI 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 24 OCT 2006 Registrar

			For State Registrar	State of N	1 arylan		artmen rtificate			and M	fental Hyg	00	06	354	92
	Dhuoisi		1. Decedent's Name (First, Middle,	Last)							2. Date of Deat Month	h Day	Vone	3. Time of	
	Physici /Medi		Avis	Martin		Dori	ot				Octobe:		2006	3:30	a^{M}
	Examir	ner	4a. Facility Name (If not institution, g		r)		4b. City,	Town, or	Location of	of Death		4c. Coun	ty of Death		
			15 Jeremy's War 5. Social Security Number 6		150 (la usa	In and the last all and	Ann If Under	apo1	is If Under:	24 Hrs		An	ne Ar		
	Funeral Director		449-01-8217	1□M 2XF	ge (<i>in yr</i> s. 91	last birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, Sept 24	Year) 1015	9. Birthi Coul Texa	place (State or ntry)	r Foreigi
			Usual Residence of Decedent								Dept 24	1913	IENA	15	
ylan	how		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside Cit	ty Limits
e Ma	-8	cto	MD Anne	Arundel		Annap	olis							1 🗆 Yes	2 X No
at ∓	or 2	Director	10e. Street and Number				10f. Zip	Code			10	0g. Citizen of	What Cou	ntry?	
aath v	- 23s	ral	15 Jeremy's Wa		. =	2 42		2140					SA		
ter de	Item	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Deceder Armed Forces 1 ☐ Yes 2X	itEverin U. }? WANA	.S. 13.	Was Deced If Yes, spec	ent of Hi ify Cuba	spanic Orig n, Mexican	gin? (Spi , Puerto	ecify Yes or No- Rican, etc.)		ace - Americ ack, White,		
urs af	, e	ğ	3 ☐ Widowed 4 Z Divorced	If Yes, Give Year or Dates			1 ☐ Yes 2	XXvo	Specify:			Speci	ity:	Whit	e
. I.S. 13-0030 within 72 hours after death with the Maryland	Cal E	Completed	15. Decedent's	Education			dent's Usua					16b. Kind of I	Business/In	dustry	
thin ;	M	npie	(Specify only highest of Elementary/Secondary (0-12)	College (1-4o	r 5+)	life.	kind of wor DO NOT us	e retired	uring most)	or work	ng				
Waryland ZIZI3-UU30	al Hygier other th		12			Intel	ligen	ce S	<u>*</u>			U.S. A			
	of oth	Be	17. Father's Name (First, Middle, La John W. Martin	st)							e (First, Middle, M		me)		
should	and Ment is marked eumatic e	ှ	19a. Informant's Name/Relationship	(Time Oriest)		405-14-25		(0)			uise Du				
42 s	th an 17 is r treur		Phyllis Emmett								I Route Number,			Code)	
ת ב <u>ּ</u>	f Health and Mental Hygiene. Item 27 is marked other than "natural", or Iteme 23a or 28a-f ehow other treumatic event, itse Medical Examiner must be notified at		20a. Method of Disposition			lace of Dispo	sition (Nam	e of			olis, MI	2140 20c. Location		own. State	
Pages	ant of nt: If I		1 ☐ Burial 2XXCremation 3 4 ☐ Donation 5 ☐ Other (Spe		8	emetery, crer tro Cr		-		0-2/			•		
Dalumore, Dermit. Pages 1 a	트립플 .	l	21. Signature of Funeral Service (C)		110							Baltim	ore,	МП	
Ď ž	Pepa Impo eny i		195 y.C	X			Hard 12 1	lest:	y Fun elv A	eral	Home, H	P.A.	MD 2	1401	
	ysician Medical		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	mplications that cause by one cause on each a. FeS p	irato	ry fo								Approximate Interval Betw Onset and D	veen
8 / 5U, sate be executed U	physicien and III the burial-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		s a consequ	uence of):	hic	puln	rona	y '	diśeasi	2		years	
Attending Physician: The law requires that the death certificat	been signed by the attending phy should be detached for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcom 1 ⊡Live birth 4 ⊡ Pregnant : 9 ⊡ Unknown	2 Fetal	Ideath 3□	Ectopic pre						ate of delive	,	ear
that	ned b e deta	Y P	Part II. Other significant conditions	contributing to death	but not resi	ulting in the ur	nderlying ca	use give	n in Part I.		23e. Did toba	acco use con	tribute to th	ne cause of de	ath?
duire 5	n sig uld biu	pe pe	left ventrular 1	upe-trophu	1, a	ortic s	itenos	is			1 ½ ☑ Yes	s 2 No	3 ☐ Prob	abiy 4 🗆 Uı	nknown
or Attending Physician: The law requires the	icete has bee r. page 2 sho	Completed by									24a. Was an autopsy perform	ed?	prior to cor death?	psy findings a mpletion of ca 2 No	
sicial	recto	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:		ED/C		Othe	~		Check only one				
2 <u>ş</u>	or this eral d	<u>ب</u>	27. Manner of Death	1 ☐ Inpat 28a. Date of Inj	ury	ER/Outpatien 28b. Time of		Ic. Injury Work	4 🗀 Nur		ne 5 🗷 Resider 28d. Describe hov			r)	
	th.	at or	1 Natural 5 ☐ Pending 2 ☐ Accident investigati	(Month, D	ay Year)	Injury	м		? 'es 2 □ N						
tal or Atte	within 24 bours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification;	3 Suicide 6 Could not 4 Homicide determine	d 28e. Place of it	njury - At ho tc. (Specify	ome, farm, stre	eet, factory,	office		1	28f. Location (Stre City or Town,	eet and Numi State)	ber or Rura	l Route Numb	er,
To the Hospital or	the Funer	edical	one) 2 Medical Ex	Physician: To the bes aminer: On the basis and manner s	of examinat	wledge, dealt tion and/or inv	estigation,	in my op	inion, deatl	place, s h occurre	ind due to the car ed at the time, da	te and place,	armet as st and due to	ated. the cause(s)	
10	To	Σ	29b. Signature and title of certifier	***			29c.	License		2	29	d. Date signe		. ,	
			* Yavs	MO				U	4416	01		10/2	23/2	006	
(o l		30. Name and address of person who Pumua Czap	MO 200	a Med	ical Pc	Print) UKWA	4	#670	A	mngpoli	MI	23/2	101-	
	Sta	te	31. Date filed (Month, Day, Year)	2006 32 Regist	rar's Signa	ture		7			1				

State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 35493 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2006 October 22, 5:20 A.M Jesus de la Cruz /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Montgomery Rockville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 200 F Director 90 Sept.12, 1916 El Salvador 555**-**69-8868 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location word! 10d. Inside City Limits r then "naturel", or items 23a or 28a-f ehove the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Directo Maryland | Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20876 11717 Zebrawood Court deeth El Salvador Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. ited within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married ltimore, Maryland 21215-0036 1 X Yes 2 □ No þ Specity: Specify: 3 Widowed 4 Divorced Salvadoran White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed withir ment of Health and Mental Hygiene. ent: if Item 27 ie marked other then ury or other traumatic event, the Ma Elementary/Secondary (0-12) College (1-4or 5+) Home 6 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be de la Cruz 2 Matilde Marta Ramos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Contreras/Grandaughter 11717 Zebrawood Court, Germantown, Maryland 20876 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Deportment Important: If any injury or once. 10/25/2006 Silver Spring, MD. 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem. 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licenses 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician neumonia /Medical resulting in death) Due to (or as a consequence of): Examiner Congrestive Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a seque e of): death certificate be executed use as the burial-transit Exam end and resulting in death) Last Due to (or as a consequence of). Box 68760 signed by the ettending physician I be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 of Vital Records, should should 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available phor to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 Yes 2 No certificate 2□ No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No ၉ 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA neret Director: After the filled in by the funeral 28a. Pate of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification; Division 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 24 hours after on Funerel Direc 4 THomicide Hospital or 29a. Certifier Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 ŝ 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2 64415 2 me October 22, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive, Rockville, Maryland 20850 Nimesh S. Shah, M.D., 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2 5 2006 Registrar

Ameı	nded it	em	1- Stata Ragistrar #17, per	State of	of Maryla	nd / Dep	artment of	Health and		/ 111	16	35494
	Physici		Decedent's Name (First, Middle	e, Last)	11/05/(00, 00	inouto or	Boating. A	2. Date of De	nag. No.	Year	3. Time of Death
	/Medic	cal	Mary Frances 4a. Facility Name (If not institution		imher)		4b City Tour	or Location of Dea	10		006	2:40a M
	Examir	ier	Atlantic Genera				Berlin	of Location of Dea	ui	Worc		
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 █ XF		. last birthday) Yrs.	If Under 1 Year Months Days		. (Month, Da	th ay, Year)	9. Birthp	lace (State or Foreign try)
	Director		214-34-7999 Usual Residence of Decedent		71	TTS.			6	11 1935	VA	<u> </u>
	arylan show	-	10a. State 10b. County	•	10c. C	ity, Town or Lo	ocation				10	Od. Inside City Limits
	death with the Maryland ms 23a or 28a-f show I must be nottified at	Director	MD Wicom	100	S	alisbu:	10f. Zip Code			10g. Citizen of V	/bat Caus	1 X Yes 2 □ No
	h with 23a or	al DI	30517 Cannon 1	r.			21804			USA	mat Coun	try ?
	tems	Funeral	11. Marital Status	Armed Fo		J.S. 13.		Hispanic Origin? (S can, Mexican, Puer	Specify Yes or No to Rican, etc.)	- 14. Race	- America	
036	within 72 hours after ene. than "natural", or ite	by	1 ☐ Never Married 2 ☐ Marr 3 🔯 Widowed 4 ☐ Divorced	ied 1 □ Yes If Yes, Gi Year or □	VB		1 ☐ Yes 2 ☒ No		*		Whit	
5-0	72 hou	eted	15. Deceden (Specify only higher	('s Education		16a. Dece	dent's Usual Occu	pation	rking	16b. Kind of Bu		
121	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			during most of wo	inig			
<u>d</u>	illed Hygid other	Be Co	12 17. Father's Name (First, Middle,	Last)		House	ewlie	18. Mother's Na	me (First, Middle,	Own Hor , Maiden Surnam		
ylar	ould be Menta arked atic ev	To B	John William Đ	avi s Crop	per			Mary A	nn Powe1	.1		
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryla I Heath and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23s or 28s-f show other traumatic event, I're Mexical Examiner must be notified as		19a. Informant's Name/Relations					t and Number or Ri				Code)
<u>ā</u>	permit. Pages 1 and 2 should be filed within 72 Department of Heath and Mental Hygiene. Important: If item 27 ia marked other than "na any nijury or other traumatic event, the Mexill QRCS.		Elnora M. Davi 20a. Method of Disposition		20b.	Place of Dispo	sition (Name of	on Dr., S	alisbury Date	20c. Location		wn, State
<u>e</u>	Page: nent o ant: If ury or		1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (S		State		matory or other pla 1 Cemeter	į.	28/2006	Berlin	,	
Baltimore,	bepartr nporte ny inju		21. Signature of Funeral Service			22	. Name and Addre	ess of Facility Th	e Burbag	e Funera	1 Ho	me
	Ø□ = € Ø		23a. Part1. Enter the disease, or	Jula complications that		10	08 Willia	ım St., B	erlin, M	D 21811		
	Physician :		Immediate Cause (Final	only one cause dr	each line.		er the mode of dyr	ng, such as cardia	or respiratory ai	rrest,		Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	aue to	(or as a consec	quence of):					_	471
1 30	Examiner	<u>.</u>	Sequentially list conditions,	b	Dene e en en	to the set of						
35	uted d ansit	Examine	any, leading to immediate cause. Enter Underlying Cause (Disease or injury	- 089 (0)	(or as a sunsac	quanee on:						
1 60 is	cate be executed by sician and the burial-transit	Exa	that initiated events resulting in death) Last	C. Due to	(or as a consec	quence of):						
111/	ate hy:	dlcal		d								
0 2 X	ath certific attending p for use as f	/Me	IF FEMALE; 23b. Was decedent pregnant	23c. If yes, out	come of pregna	ancy				22d Date	of deliver	
0. B	death e atter	Physician/Me	in the past 12 months?	1 ☐ Live b 4 ☐ Pregn	irth 2 Feta	al death 3	Ectopic pregnanc Other (specify) _	у		Mon	of deliver	y Day Year
000 P.O.	that the d ad by the detached	Phys	9 Unknown	9□ Unkno					_			
ds,	es pe	by	Part II. Other significant condition	ns contributing to de	eath but not res	sulting in the u	nderlying cause giv	ven in Part I.		obacco use contri ⁄es 2 □ No		,
F	w requir s been s should	lete	arija gara	- UW FIC	211101				24a. Was			
95 Re	The law ate has b	Completed							autop	rmed? de	eath?	sy findings available pletion of cause of
17 /	cian: sertifica actor, p	Be	25. Was case referred to medical examiner?						th (Check only o			: BL 140
27.2	Phyalcian: r this certific ral director,	2	1 ☐ Yes 2 No 27. Manner of Death			ER/Outpatien		4 🗆 Nursing H		lence 6 Other		
100	ttending Ph death. tor: After th the funeral	Certification;	1 Natural 5 Pending 2 Accident investig		of Injury th, Day Year)	Injury	28c. Injur Wor M 1	rk? Yes 2□No	28d. Describe i	low injury occurre	a	
Z Z	I or Atten after deat Director: I in by the	rtific	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 286. Place	of Injury - At he	ome, farm, stre	eet, factory, office		28f. Location (S City or Tow	Street and Number	r or Rural	Route Number,
0% D			29a. Certifier 1 Certifyin	Physician, To the	hoot of mules							
	To the Hos within 24 ho To the Fun completely i	Medical	(Check only one)	Physician: To the examiner: On the ba and mann	best of my kno asis of examina ner stated.	wieage, death ition and/or inv	occurred at the tirestigation, in my o	me, date and place pinion, death occu	, and due to the or rred at the time, or	cause(s) and man date and place, ar	ner as sta nd due to t	ted. he cause(s)
	To the I	Ĕ	29b. Signature and title of certifier		1		29c. Licens			29d. Date signed		
			The Van E	amon	1 M	0	Do	05630	7	October	25	2006
P	A2		30. Name I d address of person T WAN FOMED	o ompleted caus	e of death (Item	n 23a) (Type, I	Print)	1/2 9720	Hentthi	MILLEDO	Boul	m, MD21811
	Stat	te	31. Date filed (Month, D. y, Year)	32.7	gistrar's Signa	ature	- M	1133	MAININ	wy Dr.	DEVI	ווצוגעווון וזו
	Registra	ar	OCT 2 6	2006	die.	A A	2042					

State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician RHODA MARIAN DEYAK 8:53 AM OCTOBER 18, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death CASEY HOUSE ROCKVILLE MONTGOMERY 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month. Day. Year) Birthplace (State or Foreign
Country) 1 □ M 2 □ TE Months Days Hours Min Director 477-20-3152 83 MINNESOTA MARCH 06, 1923 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location item 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits MARYLAND MONTGOMERY Director ROCKVILLE 1 ☐Yes 2 ☒ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6813 STONEWOOD TERRACE Funeral 20852 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 No Specify: Completed by 3 X Widowed 4 ☐ Divorced Specify. WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 HOME MAKER OWN HOME permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: if item 27 is marked othe any injury or other traumetic svent, and injury or other traumetic svent, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JOHN KAATIALA SUSAN VIITALA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TIMOTHY DEYAK - SON 6813 STONEWOOD TERRACE, ROCKVILLE, MARYLAND 20852 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State FORT LINCOLN CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) 10/24/2006 BRENTWOOD, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facilit HINES-RINALDI FUNERAL HOME, INC. Mychin Wholes LISOU NEW HAMPSHIRE AVENUE, SILVER SPRING, MARYLAND 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** ASPIRATION PNEUMONIA /Medical Due to (or as a consequence of) Examiner SENILE DEMENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed use as the burial-transit the attending physicien and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 should be HYPERTENSION 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed been HYPOTHYROIDISM 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? hes certificate 2□ No 1 Yes 2 No 1 ☐ Yes To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one To Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 AOther (Specify) HOUSE 1 ☐ Yes 2 🔀 No 2 ER/Outpatient 3□ DOA After the 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 X Natural 5 Pending investigation Injury I Dirsctor: A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Rynthia M Delliams Do H0058032 October 18, 2006 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CYNTHIA M. WILLIAMS, D.O., MONTGOMERY HOSPICE, 6001 MUNCASTER MILL ROAD, ROCKVILLE, MARYLAND 20852 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2006

DHMH 17 Rev 1/2001

Registrar

24

			For State	State of	Maryi	and / Depa	artment o	of De	alth and	Mental	Hygien	2006	35496
			1. Decedent's Name (First, Middle, L	ast)		Cei	uncate	OI DE	aui	2. Date	Reg. No	0.	2 Time of Death
	Physici	an	'	A T	SEI	MBY				Mont	n Da	ay Year	3. Time of Death
	/Medio		4a. Facility Name (If not institution, g	in chart and and		101	th City Tay			10	21	2004	5 8:30 PM
	Examir	er		*			4b. City, To	wn, or Lo	cation of Deal	1 1 :	40	c. County of Deat	.n
			Baltimore Reta			yrs. last birthday)	If Under 1 Y	ear If	Under 24 Hrs	8. Date	re.	O Rie	hplace (State or Foreign
	Funeral Director		213-46-1116	iXM 2□F	59	Yrs.			Hours Min.		h, Day, Year	1946	ountry)
		1	Usual Residence of Decedent							200	CQ I	שדירו	
	show		10a. State 10b. County		10c	. City, Town or Lo	cation						10d. Inside City Limits
	B-1 s	Ş	MD HARE	ORD			EDGEWO	OD					1X Yes 2 □ No
	or 28	le	10e. Street and Number				10f. Zip Co	de			10g. Ci	itizen of What Co	untry?
	23e c	a	1712 DEARWOOD	COURT			2	1040				USA	
	ems ems	Funeral Director	11. Marital Status	12. Was Dece			Was Decedent f Yes, specify	of Hispa	inic Origin? (S	Specify Yes	or No-	14. Race - Ame Black, White	
98	or it	Ę,	1 Never Married 2 Married	1 XYes If Yes, Give	2 🗌 No		1 ☐ Yes 2 🔯		pecify:		.,		
5-0036	72 hours after death with the Maryland neturel', or Items 23e or 28e-1 show areal Expedient qual be neitlied at	d by	3 ☐ Widowed 4 X Divorced	Year or Da	tes: 196	6-71						Specify: BI	
7	"net	Completed	15. Decedent's (Specify only highest g			(Give	ient's Usual O kind of work d	one durir	n ng most of wo	rking	16b. k	(ind of Business/	Industry
2121	within ene. than "	ם	Elementary/Secondary (0-12)	College (1-	4or 5+)	me. I	DO NOT use n		כוינו			DET TO	THOSE
	filed with Hygiene. ther than	မ င်	17. Father's Name (First, Middle, Las	st)			IKUCK		E.K. . Mother's Nai	ma /Firet M	iddle Maider	DELIV	EKY
au	Mental Mental arked o	m	HOWARD DEMBY	/								r Surname)	
7	should nd Men marke umatic	ဥ	19a. Informant's Name/Relationship	(Type Print)		19h Mailin	a Address /St		EBECCA			or Tour State 3	To Code l
Maryland	d 2 sho th and th sma trauma		BRUCE M. DEMBY, J								-	or Town, State, Z GRACE, M	
	ges 1 and 2 should be filed within 72 hours after death with the Maryla of Heath and Mental Hygiene. If item 27 is marked other than "neturel", or Items 23e or 28a-1 show if item 27 is marked other than "neturel", or Items 23e or 28a-1 show or other traumatic event, If a Modical Examiner must be notified at		20a. Method of Disposition	,	20	b. Place of Dispo			COOKI	Date		ocation - City or	
Baltimore,	0 0		1 🔀 Burial 2 □ Cremation 3		State	ASBURY C	-		10/2	E / 0.6	1		
<u>=</u>	artme artme orten injury		* 4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Lice	-			. N <u>ame an</u> d A		10/2	5/06	CHUI	KCHVILLE	, MARYLAND
Ba	permit. Pag Department Importent: I any injury o		die Jan	H - Colo	me	1	LISA	SCOT	T FUNE	RAL HO	ME, P.	Α.	
			23a, Part1. Enter the disease, or con	nolications that ca	used the c	death. Do not ente	552 L	EWIS dving st	STREET	Correspirate	RE DE	GRACE,	MD 21078 Approximate
			23a. Part1. Enter the disease, or con shock, or heart failure. List onl Immediate Cause (Final	y one cause on ea	ch line.	1	۱ م	-,g,			.,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a Kest	sira	sequence of	Faul	we					
	Examiner			COL	o h		01.01.	Sm					
	• **	e	Requentially list conditions if any, leading to immediate	Due to (c	or as a con	sequence of):	zui u	311)					
	uted d ansit	mi	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events					7.7					
Ć	exec in an	Examiner	resulting in death) Last	Due to (c	r as a con	sequence of):							
68760,	icate be executed physician and s the burial-transit	edical		d									
99	tificate ig physi as the l		-										
ŏ	ndir use	N/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc			le				11	23d. Date of deli-	very
m.	death e atte	icla	in the past 12 months?	1□Live bir 4□Pregna	nt at time		Ectopic pregn Other (s <i>pecif</i>)					Month	Day Year
P.0	at the de by the a tached	Physiclan/M	9 🗌 Unknown	9□ Unknov	wn								
	law requires that the as been signed by th 2 should be detache	by P	Part II. Other significant conditions	contributing to dea	ath but not	resulting in the un	derlying cause	given in	Part I.	23e. l	Did tobacco	use contribute to	the cause of death?
ord	w raquire bean si should b										1☐ Yes 2	No 3□Pro	bably 4 Unknown
900	aw re ts be 2 sho	Completed									Mas an	24b. Were aut	opsy findings available
Ä	9 4 9	mo:								1 D Y	autopsy performed? es 2 No.	death?	ompletion of cause of
Vital Records,		0	25. Was case referred to medical					26.	. Place of Dea			10,165	20 140
f V	is di	To B	examiner? 1 ☐ Yes 2 XNo	Hospital: 1 🗌 In	patient 2	ER/Outpatien	3 DOA	04				6 □Other (Spec	ifv)
J Of	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of	Injury , Day Year	28b. Time of Injury	28c.	njury at Work?		,	ibe how inju		,,
<u>0</u>		atlc	2 Accident investigation	on	, Day Tou.	, injury			2 🗆 No				
Division	or Atten after deat Director: in by the	tific	3 Suicide 6 Could not determined	28e. Place	of Injury - A	At home, farm, stre	et, factory, off	ice		28f. Locati	on (Street an Town, State	d Number or Rui	al Route Number,
Ö	tal or A rs after el Dire ed in b	Certification;		Danan	g, oter (op					Ony of	rown, State	2)	
	To the Hospital of within 24 hours af To the Funerel D completely filled in	edical	29a. Certifier 1 Certifying P	hysician: To the b	est of my	knowledge, death	occurred at the	e time, d	ate and place	, and due to	the cause(s)	and manner as	stated.
	To the H within 24 To the F complete	ledi		and manne	er stated.								
	To Con	Σ	29b. Signature and title of certifier	0- 0	0		i	ense nur		PA		te signed (Month,	
,			DAMPS 19	SOOK, 1	W		M	00	1-269	2 L	00	tal, a	1004
7 +	IVA		30. Name and address of person who		of death (Item 23a) (Type, F	Print)	~					
_	1V/-			ck, MD	39	50 LOC	A RAVE	ENB	xoute1	god,	Balk	more m	D 21218
	Sta Registr		31. Date filed (Month, Day, Year) 4	2006	gistrar's Si	griature 4	rester			Ť			

/Medical Examiner the death certificate be executed Division or Vital Records, P.O. Box 68760, or Attending Physician;

attending physician for use as the buria signed by the a After this certificate funeral ours after death, neral Director: A filled in by the fu within 24 hours a To the Funeral I

Funeral

Director

show

ms 23a or 28a-f show

7 is marked other than "natural", or items traumatic event, the Medical Examiner mi

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after deau Department of Health and Mental Hygiene. Important: If frem 27 is marked other them any Injury or other trainmant.

Physician

	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	one cause on each line.	th. Do not enter the		liac or respiratory arres	st,	Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consec	Cance				3years
De Completeu by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate produce of the conditions	b. Due to (or as a consect Due to (or as a consect Due to (or as a consect d.	quence of):				
ysicidi i/ iviet	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome pf pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	ai death 3 □Ectop	ic pregnancy (specify)		23d. Date of del Month	livery Day Year
י לא הסויהומיווסי	Part II. Other significant conditions of	ontributing to death but not res	sulting in the underlyi	ng cause given in Part I.	1 ☐ Yes 24a. Was an autopsy	2 No 3 Pr	othe cause of death? robably 4 □Unknown utopsy findings available completion of cause of
	25. Was case referred to medical examiner?			26. Place of E	eath (Check only one)		2010
	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 Residen	ce 6 □Other (Spe	cify)
	27. Manner of Death ★ Natural 5 Pending 2 Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how		
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Speci		ctory, office	28f. Location (Stre City or Town,	et and Number or Ru State)	ıral Route Number,
	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death occur ation and/or investiga	red at the time, date and plation, in my opinion, death of	ace, and due to the cau occurred at the time, dat	ise(s) and manner as e and place, and due	s stated. e to the cause(s)
	29b. Signature and title of certifier	`		29c. License number	290	d. Date signed (Monta	h, Day, Year)
	1000	the MO		D5874	7	10/23/20	006
Ī	30. Name and address of person who o	completed cause of death (Iter	m 23a) (Type, Print)				

State

Registrar

OCT 2 4 2006

(1) az

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 27 **Physician** 2006 Year 5:02 P M MAE DEVILBISS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 🗓 X F Director 507-20-5186 80 Iowa 2/10/1926 Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Frederick MD Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be USA 21702 9222 Opossumtown Pike Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry be filed within 7 tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 Home Maker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If item 27 is marked othen any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mabel Ila Petty Orville Frederick Pigga 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9222 Opossumtown Pike Frederick, MD 21702 Daughter Deanna Webb 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Mount Olivet Cem. 11/1/2006 | Frederick, Maryland 22. Name and Address of Facility Keeney & Basford P.A. F.H. 21 Signature of Funer Service Licenses Mari M00176 106 East Church Street Frederick, MD 21701 23a. Part: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final emplete aute **Physician** disease or condition resulting in death) /Medical Due to (ar as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner resulting in death) Last Due to (or as a consequence of): Box 68760, physician s the burial Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death ed by the a P.0. 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, à beitension 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has 2 No 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ပ After this Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death al or Attending F s after death. Certification: 5 ☐ Pending investigation 1 Natural Injury within 24 hours after death.

To the Funeral Director; Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



D 54636

October 30, 2006

		•	For State Registrar	State of Ma	aryland	-	rtmen tificate			nd Mer		iene .g. No.20 () 6	351	+99
	Physici	an	Decedent's Name (First, Middle, Last	st)							Date of Dear	Day	Year	3. Time of	
	/Medic	al	Christ Economos 4a. Facility Name (If not institution, give	e street and number)			4b. City.	Town, or	Location of		ccoper	21, 200 4c. County o		6:20	рм
	Examin	ier	Montgomery Hospi		House				ville			Monto	jomei	ry	
	Funeral Director		5. Social Security Number 6. S 141-30-2589 1	ex 7. Ago M 2□F 67	e (In yrs. las	s <i>t birthday)</i> Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	Date of Birth (Month, Day, Ct. 8,	Year)	9. Birthp Coun	lace (State o itry) York	or Foreign
	p >		Usual Residence of Decedent 10a. State 10b. County		10c City	Town or Lo	cation						1	0d. Inside C	ity Limits
	Aaryla Febor	ō		jomery	,	ilver		nα							2 X No
	r 28a-	Director	10e. Street and Number	JOINEL J		11401	10f. Zip				1	0g. Citizen of Wi	nat Cour	itry?	
	th with	a D	14440 Astrodome	Drive					20906				JSA		
Maryland 21215-0036	72 hours after death with the Maryland neturel', or iteme 23e or 28e-f ehow dical Examinermust be notified at	by Funeral	11. Marital Status * Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 1 Yes, Give Year or Dates:			Vas Deced í Yes, spec I □ Yes		spanic Orig n, Mexican, Specify:	in? (Specify Puerto Ric	y Yes or No- an, etc.)	14. Race Black Specify!	, White,	etc.	
5-0	"netur	eted	15. Decedent's Ed (Specify only highest gra			16a. Deced (Give	lent's Usua kind of wor	l Occupa rk done di	tion uring most	of working		16b. Kind of Bus	iness/Ind	dustry	
121	f within piene. r then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)	life. I		se retirea) lerk				Retail			
d 2	Hygi Hygi Sther	0	17. Father's Name (First, Middle, Last)						18. Mother	's Name (F	irst, Middle, I	Maiden Sumame)		
/lan	0 2 2 0	To B	Moses Economos						Atl	hena 1	Kaci				
Aan	and and ie m		19a. Informant's Name/Relationship (, City or Town, S			
	1 en Heal em 2 ther		V. Bess Penczak/ 20a. Method of Disposition	Sister	20b. Pla	ce of Dispo	sition (Nan	ne of		Drive		ver Spri 20c. Location - C			905
μÕ			1 Surial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif			netery, cren of Hea				ctobe 2006		Silver S	Sprin	ng. Ma	rvlan
Baltimore,	permit. Page Depertment Importent: If eny injury or		21. Signature of Funeral Service Licer							ins F	uneral	Home In lver Spr	ıc.	-	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lir	the death. ne.	Do not ent	er the mod	e of dying	j, such as c	eardiac or re	espiratory arr	est,		Approximat Interval Bet Onset and	ween
	Physician		Immediate Cause (Final disease or condition resulting in death)	a Coronar			sease	е						Original daries	Dou
	/Medical Examiner		f and a second	Due to (or as											
		Jer	Sequentially list conditions, if any, leading to immediate	b. Diabetes Due to (or as	a conseque	nce of):									
	ocuted nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c											
8760,	cate be executed physicien and the burial-transit	E E	resulting in death) Last	Due to (or as	a conseque	ince of):									
687	ficate I physi s the b	edicai		d											
Box .	Physicien: The law requires that the deeth certificate be executed this certificate has been signed by the attending physicien and rall director, page 2 should be deteched for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal d	leath 3	Ectopic pr Other (sp					23d. Date Mont		*	Year
, P.O.	s that t ned by a dete	by Ph	Part II. Other significant conditions of	ontributing to death b	ut not result	ing in the u	nderlying c	ause give	n in Part I.		23e. Did tol	pacco use contrib	oute to th	e cause of c	death?
rds	requires been sign should be	ed b					_			_	1 🗆 Ye	es 2 □ No 3	B 🗌 Prob	abiy 4 🖄	Unknown
I Records,	The law requate has been page 2 shoul	Completed									24a. Was a autops perform	ned? de	or to coreath?	psy findings npletion of c 2 No	available cause of
Vital	certifical	Be	25. Was case referred to medical examiner?	Hospital:				Othe			heck only on	7		Vocni	
o		7: To	1 Yes 2 No 27. Manner of Death	1 Unpatie	rv 2	R/Outpatien 8b. Time of		8c. Injury Work	4 🗆 1401			ow injury occurre		hiospi	
ion	Attending I r death. ector: After by the funer	atior	1 Natural 5 Pending 2 Accident investigation	(Month, Day	y Year)	Injury	м		? ′es 2 □ N	io					
Division	Z =	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injuding, etc.	ury - At hom c. (Specify)	ne, farm, str	eet, factory	, office		28f	Location (Si City or Town	reet and Number n, State)	or Rura	l Route Num	nber.
	Hospit 24 hour Funer tely fills	Medicai (ysician: To the best niner: On the basis of and manner sta	examination										S}
	To the within 2 To the comple	Ž	29b. Signature and title of certifier	04 4	•			. License		-		9d. Date signed			
	10		Cynthia m					100	580	ゴ ん		October	123	,200	0
			30. Name and address of person who Cynthia Williams	s, D.O. 60	001 Mt	uncast	er M	i.11 F	Road,	Rocky	ville,	MD 2085	5		
	Sta Regista		31. Date filed (Month, Day, Year) OCT 2 5 2		ar's Signatu	re Ap	ule								

			1 - For Amen State Amen Registrar	d item#23a	State of 25,27,28	of Maryla a-f, perl	nd / Depa Æ, gs61	artment of 111/27/06 tificate of	Health a Death	and Men	tal Hyg	iene 9. No. 2 () (16	35500
	Physic /Medi		1. Decedent's Nam	e (First, Middle, I						2. [Date of Deat Month Ct.	Day Y	ear 006	3. Time of Death 0525
	Examir	ner	Dorches	_			1	4b. City, Town, Camb	or Location o			4c. County of Dorc		ter
	Funeral Director		5. Social Security N	-2321	.Sex 1 □ M 2 🔼 F		i. last birthday) 3 Yrs.	If Under 1 Year Months Days		24 Hrs. 8. 5 Min. J u	Date of Birth Month, Day, Ine 9	, 1953	Birthpla Country Mar	ce (State or Foreign y) yland
	aryland •how	2	Usual Residence o 10a. State MD	10b. County	cheste		ity, Town or Lo						100	d. Inside City Limits 1 ☐ Yes 2X No
	or 28a-f	Funeral Director	10e. Street and Nu	mber				Hurl 10f. Zip Code	оск		10	g. Citizen of Wha	at Country	
	sath wil	erai D	3816 W	cights					643			Jnited		
21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. If Item 27 is marked other then "netural", or Items 23a or 28s-f show or other traumatic event, the Maxilcal Examinat must be notified at	۾	11. Marital Status 1 ☐ Never Marr 3 ☐ Widowed	ied 2. Married 4 □ Divorced	Armed Fo	2 x xNo		Vas Decedent of i Yes, specify Cut	an, Mexican	gin? (Specify , Puerto Ricai	Yes or No- n, etc.)	14. Race - Black, 1 Specify:	White, etc	
15-0	in 72 h	Completed		15. Decedent's ify only highest of	grade completed)		16a. Deced	lent's Usual Occu kind of work done OO NOT use retire	pation during most	of working	1	6b. Kind of Busin	ess/Indu	stry
212	ed with ygiene.	Com	Elementary/Seco		College (1-4or 5+)		gistere	d Nu	rse		Instit	utio	on
Maryland	2 should be filed within and Mental Hygiene. 7 is marked other then "reumatic event, Its Max	To Be	17. Father's Name Franci		r Wrigl	nt						daiden Sumame) Lenno	n Bı	adley
Man	id 2 sho lih and l 27 is ma traums		19a. Informant's Na Edward			other						City or Town, Sta		
	es 1 and of Health if Item 27 or other tr		20a. Method of Disj	position	☐Removal from	20b.	Place of Dispo- cemetery, cren	sition (Name of natory or other pla	ice)	Date	2	0c. Location - Cit	y or Towr	
Baltimore,	Pa Part C			5 ☐ Other (Spec	cify)	Mi	d Shor	e Crem	.Ctr.	10/31	/06 C	cambrid;	ge,	MD
Ba	permit. Departr Imports eny Inju) Car	isting	m.	Dal	e Fr	Name and Address amptom	Fune burg,	ral H MD	оте 2163 ₂	PA		
	Physician /Medical Examiner	_	23a. Part1. Enter the shock, or hea Immediate Cause disease or condition resulting in death) Sequentially list confiany, leading to immediate the shock of the	(Final n	a. Due to	50 . 0	quence of):	er the mode of dyi	ng, such as c	toba (piratory arre	cdes	In	pproximate Iterval Between Inset and Death
58760,	cate be executed physician and the burial-transit	dical Examiner	cause (Disease or that initiated events resulting in death) I	injury	c. fr	(or as a consec	ussig	Depa	ess'	- STORM	ROVED BY ME	DICAL EXAMINER		
.O. Box (death certiff e attending d for use as	Physician/Me	IF FEMALE: 23b. Was decedent in the past 12 1 Yes 25 9 Unknown	months?		inth 2 ☐ Feta ant at time of c	al death 3 🗌	Ectopic pregnanc Other (specify)		UECHTO!		23d. Date of Month	delivery Da	ay Year
rds, P	w requires that been signed should be del	þ	Part II. Other signif	cant conditions	contributing to di	eath but not res	sulting in the un	derlying cause gn	ven in Part I.		23e. Did toba	cco use contribut	robabl	
Vital Records,	The lar	Completed									24a. Was an autopsy performi ☐ Yes 2	24b. Were prior deat	n?	r findings available letion of cause of
f Vit	Physicien: T this certificet al director, pa	o Be	25. Was case referrexaminer?	ed to medical	Hospital:	npatient 2	ER/Outpatient	3□ DOA Ott		of Death Che		ce 6 □Other (5	Sagarhi)	
on of	fer fer	Ion: T	27. Manner of Death	5 Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury	28c. Injur	y at rk?	28d. [injury occurred	эр ө спу)	
Division	deat deat ctor: y the	Certification;	2 Accident 3 Suicide 4 Homicide	investigation 6 X Could not determine	be 28e. Place		ome, farm, stre	et, factory, office	Yes 2 XN	Ca.s.	CHOWN ocation (Stre	et and Number o	r Rural R	oute Number S Wharf Road
Ö	To the Hospital or I within 24 hours after To the Funeral Directorpletely filled in b		29a. Certifier	10 artifying E	found	: home				Hurl	Lock, MI)		
	the Hos in 24 h the Fur ipletely	ledical		2 Medical Exe	miner: On the ba	isis of examina	ation and/or inv	estigation, in my c	ppinion, death	n occurred at t	the time, dat	se(s) and manne e and place, and	r as state due to the	ed. e cause(s)
	To To con	2	29b. Signature and	0	2	MD		D- 6	336	0	290	Date signed (M	onth, Day	v. Year)
			30. Name and addre	iss of person who	Completed caus	e of death (Ited	23a) (Type, F	grint) Er (gen.	Hosp	Tal	Camp	mid4	2 MD
章.	Sta Registr		31. Date filed (Mont	h, Day, Year) V = 2 200		egistrar's Signa	ature	Es .					0	,